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THE BUBONIC OR ASIATIC PLAGUE; ITS SYMPTOMS AND PATHOLOGY.[1]

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The disease known and described as the bubonic or black plague, black death, the pest and the plague Asiatica, that has so viciously and fatally attacked the inhabitants of the southern part of China, and the ports of Japan having commercial relations with Chinese ports, is no doubt a near relative, clinically and pathologically, to that pest of pests that at various periods swept over Europe and Asia, and left its footprints on a trail of horrible devastation rarely paralleled in medical history.

A vista of the past upon whose time worn sign-posts we see the imprints of this frightful scourge, leads us back to the cradle of humanity—Egypt. According to Rufus (A. D. 98–117) it was endemic and epidemic in Egypt and Syria 2000 B. C. Appearing in Europe during the reign of the Emperor Justinian (A. D. 527–565), its ravages were horrible, and it extended to the limits of the then known world, marked by a mortality of awful dimensions. It may be said to have become a permanent resident of Europe for the next 1,200 or 1,300 years. Although the black death is reported as presenting an aspect somewhat differing from the plague, much of the hideous description of the writers of the fourteenth century may be ascribed to the superlative degree of their real and imagined danger and their unwholesome ignorance. The offensive gangrenous odors and other symptoms of the black death are wanting in the plague, and the rapidity of its fatal course is a distinguishing feature, but many other symptoms are so similar that it is difficult to think it other than identical with plague. It would seem strange that so grave and horrible a malady could have sprung spontaneously upon the human family—spread itself like a pestiferous cyclone, and then have disappeared entirely from us.

The two epidemics that have in recent years devastated the sections of China and Japan above mentioned, have given an opportunity of carefully observing and studying this ancient and interesting scourge. To the medical laborers in that field much is due, and coincident with the meteor-like fame of his country, that still lightens the eastern world, is the honored name of Kitasato, the bacteriologist and scientist. As a result of the work done there, I am able to present the following exact description of the disease as noted and studied by the physicians in charge of the Plague Hospital at Hong Kong, which was obtained by Dr. Sprague of the steamer Gaelic, and kindly given to me. It will be found to be exhaustive and interesting, and rich in many new and important symptoms hitherto unpublished:

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[1] From notes obtained by Dr. F. F. Sprague, Surgeon S. S. Gaelic; from Dr. Dr. Wilna, the Physician in charge of the Plague Hospital at Hong Kong.

Clinical Symptoms and Pathology.—Most of the cases begin without prodromic symptoms. Europeans, and servants of Europeans, generally show a sudden development of the disease in the middle of work, having felt quite well up to the time of the attack. The fever begins suddenly, and prostration and other well-known symptoms of plague rapidly set in. In from one to five or six days after fever begins, the glands begin to swell (at least as far as they are perceptible by palpation.) Some cases show prodromal signs, but they are the minority.

There has been a marked *facies* in the disease. Congestion, sometimes increased even to suggillation round the eyes and on the forehead and cheek bones ("black death"); apathy to surrounding events, a certain painful tension, caused by oppression; glowing or injected eyes, soon sinking back into the sockets; the expression of extreme weakness; dry lips, until the latter stages of the disease covered with sordes—are the roughly described characteristics of the plague face.

The tongue is swollen, furred, sometimes dried up, brownish or black, as the disease progresses, occasionally with cracks or fissures, and resembles the worst tongue of the third week of typhus or typhoid fever. In light attacks, or in those with a very rapid course, this dry stage does not develop so quickly.

The other symptoms of the intestinal tract are want of appetite, great thirst, vomiting, constipation, and in many cases, later on, diarrhea, with bloody evacuations. These symptoms may generally be explained by the fever, but in some cases they are apparently signs of alterations in the structure of the enteric mucous membrane. Indeed, in about 20 per cent. (30 in 150 cases) hemorrhages were found underneath the epithelium of the mucous membrane of the stomach and intestine, in most cases as petechiæ with circumscribed edges, but occasionally diffused. The lymphatic follicles and Peyer's patches were swollen in most cases, sometimes elevated, and occasionally detached, leaving ulcers without slough and with floating edges or margins. Simple injection of the mucous membrane could be seen in nearly all of the cases, but there were some in which the alterations were so general in the intestine that the whole disease seemed to be a primary infection of the intestinal tract, with subsequent infection of the blood, especially if there were no externally apparent localizations of the swollen glands. This occurred in 133 cases out of 150. Apparent or marked localizations are to be understood as painful swellings of the glands, exceeding, say, the size of a bean.

The respiration was dyspenic if there was a high temperature. In 20 cases out of 150 there was bronchitis and hypostatic inflammation. Hemoptysis occurred in 15 cases—10 per cent. Infection of the bronchial tubes and simple edema occurred in nearly every case. The cases of bronchitis with bloody expectoration appeared to be mere localizations of the plague germ, as in most cases, externally apparent buboes were observed. Predisposing catarrhs may have provided a good soil for the growth of the bacillus. The bacilli never here gave rise to destruction of tissues. Tubercular disease was only evident in one case. The mortality in bronchitis cases is the same as in non-bronchial fevers.

Fever was present in every case, but varied greatly in amount. There was no regular typhoid curve of the fever, as is usual in almost all the other infectious diseases. It rises in some cases to 106° F., whilst in others it may only reach 102° F. The height of the temperature is no measure of the severity of the disease, as patients with little fever of short duration also die. The duration of the fever is usually from a few hours to some weeks. In about 30 per cent. of the recovered cases the fever of the infection lasts about five or six days, and this may be regarded as typical. It is high at the beginning, and sinks slowly down with frequent morning remissions. It may last as long as ten days. After this primary fever a secondary fever occurs in a majority of recovering cases. This is the fever of absorption, and may lead to weeks of exhausting illness, and cases may die at this stage which were saved in the battle of infection. This fever is very irregular in duration and height, varying according to the extent of destruction and reabsorption of the affected glands.

The skin is in all cases dry and hot. In some cases cold perspiration occurs just before death. There was never anything like a critical or lytic sweat observed. Petechiæ of the body were only seen in two cases. Herpes occurred in a few cases also. Four so-called carbuncles were seen. Wounds of the skin were rare and never irritated, no lymphangitis being present.

Nervous symptoms are caused by the fever and the overloading of the blood with infectious materials. There is generally tremor, deafness, unconsciousness, delirium—in some cases of a violent character.

The heart's action was always weakened, and in many cases dilatation of the right side occurred, systolic murmurs, and other signs of weakness being apparent.

The urine always showed the presence of albumin in the greater number of cases, ranging from 1 per cent. to 5 per cent. of albumin. In the beginning retention of urine was frequent. The kidneys were congested, the capsules often showing hemorrhages. Abscess of the kidney was never seen, neither was abscess of the liver.

The gall-bladder was usually distended. The spleen was usually swollen and congested, the malpighian corpuscles being prominent on the surface of a section.

Enlargements of the Glands.—Having considered the general symptoms of plague, I shall now take up its most prominent characteristics, namely, the swollen glands. These may be either superficial and palpable, or intestinal and internal, or a combination of both. The affections of the glands might be called a "polyadenitis hemorrhagica infiltrativa"—a multiple inflammation of the glands with hemorrhagic infiltration of the glandular tissues, with a tendency to infiltrative periadenitis, spreading from one gland to another centripetally and forming chains of infiltrated glands. Some of the glands break down. Infiltration may develop very quickly, even in a few hours, and sometimes produce an extensive cellulitis.

The time of development of palpable adenitis is irregular; it may be marked and evident in the first hours of the disease. Even large buboes may form in a few hours after a time when a person has felt absolutely in the best of health. On the other hand, we frequently see a patient dying of plague without our being able to feel one single affected gland, and only thorough *post-mortem* examination shows the slightly swollen glands of lentil, pea, or almond size, which exhibit the plague bacillus by microscope and culture tube.

The plague gland, in the polyadenitis form, is clinically, in many cases, indistinguishable from the gland of syphilis, scrofula, and lymphadenitis of ordinary systemic origin. In many cases the plague gland shows a boggy, gummatous fluctuation, very tender on pressure, and complicated with a hemorrhagic suffusion of the skin over it. Out of 150 cases admitted alive into the hospital, the following table shows the localization of the glandular swelling at the onset of the disease. There were 80 males, 22 females, and 48 children:

Unilateral Inguino-Femoral	48	per cent.
Bilateral Inguino-Femoral	9—6	per cent.
Unilateral Axillary	13—8.5	per cent.
Bilateral Axillary	0 —	per cent.
Unilateral Cervical	14—9	per cent.
Bilateral Cervical	2—1.3	per cent.
Unilateral Submaxillary	3—2	per cent.
Bilateral Submaxillary	0 —	per cent.
Cubital Unilateral	1—.75	per cent.
Multiple Buboes	4—2.7	per cent.

Thirty-three cases or 22 per cent. were received without an apparent bubo. In most of the cases multiple adenitis was found—the general size of the gland being that of a lentil. In the latter stages of the disease other buboes formed in different localities and complicated the cases. Ninety per cent. of the cases showed swelling of the intestinal, bronchial, and mediastinal glands in different stages.

Mortality.—The mortality of the patients admitted to the hospital was 80 per cent. The general mortality must be much greater, as most of the bad cases die before being discovered, or in course of transmission to hospital; 76 per cent. died during the first 6 days, 4 per cent. died later on from the 7th to the 19th day. The former died from the severity of the disease itself, the latter from the after effects, mainly exhaustion and suppuration. Deaths are generally caused by paralysis of the heart, in other cases from the brain mischief. The temperature at death is sometimes very high, sometimes subnormal. Convalescence is generally prolonged and often complicated by suppurative fever.

Microscopy and Bacteriology.—Microscopical and bacteriological examination has been very much handicapped by the absence of a large amount of apparatus which is quite indispensable for full investigation in this branch of science, and most of the apparatus had to be supplied promptly. The work can, therefore, be regarded as incomplete till more apparatus arrives from Europe. Only a few facts can now be given, which already seem to be very promising for future work.

The examination of the blood on reception of the patients in the hospital, was the first object for attention, as the most easily procurable material for the diagnosis of doubtful cases. By the microscope alone, the bacillus was detected in the blood in 32 cases out of 45 examined, *i. e.*, 71 per cent. Cultivation of the blood on gelatine and agar-agar gave 29 positive results out of 35 cases; 6 cultivations were negative. This gives 83 per cent. with positive results by cultivation.

Of the first 32 patients, 26 died, whilst of the latter 29 cases, 25 died. These numbers show that one is able to fix the bacillus in the great majority of severe cases in the early stages, by careful microscopical examination, whilst 10 per cent. more can be recognized by cultivation experiments. In one case streptococci were also found.

Examination of discharges from newly opened buboes and abscesses showed, in all cases, the presence of the plague bacillus. In about half the number of cases streptococci and staphylococci were found. The number of the bacilli usually corresponded to the advancement of the swelling and destruction of the gland.

The sputum of 12 plague patients suffering from bronchitis, showed 11 positive results on cultivation. One cultivation was negative. In 2 cases of cultivation from fur on the tongue, the plague bacillus developed on gelatin. The culture examination of feces gave positive results in all of the 15 cases examined, where well marked enteric symptoms were present. In 8 of those cases no externally apparent bubo was present.

After *post-mortem* examinations, the various internal organs were frequently examined. In all cases the tissue of the spleen, and in most cases the liver, mucous membranes of the stomach and intestines, and of the lungs, gave positive results by culture and subsequent animal experiments. All these examinations were made carefully and the positive results are beyond any doubt. As they were made with imperfect apparatus, further experiments will prove more than this. It is hoped that it will soon be possible to state whether or not the bacillus is present in the soil of the colony at different places, in the dirt of infected houses, in the water and in latrines, clothes of infected persons, etc.

Inoculation Experiments on Animals.—The following inoculations were performed upon different animals. Of these, 2 pigs, 3 monkeys, 1 cat, 6 rabbits, 17 guinea pigs, 3 mice were inoculated. The inoculating substance was diseased tissue and pure culture. There were 2 with splenic tissue, 2 with fur from the tongue, 1 with blood culture, 2 with pus cultures, 4 with sputum cultures; 4 guinea pigs and 2 monkeys died from plague without being inoculated. Of 18 animals inoculated in the abdomen, 17 gave positive results—that is to say, they afterward died of plague.

Implantation of diseased tissue and pure culture into the stomach by feeding or introducing them into the esophagus by means of a glass tube, was performed in 9 cases with 5 positive results. These cases died showing clinical and anatomical symptoms of plague, whilst under observation and on the *post-mortem* table. The other ones, 2 rabbits, 1 cat, and 1 guinea pig, were sick for a week, showed irregular fever, but recovered.

The 1 case of subcutaneous inoculation which did not die was that of a pig which showed local inflammation round the site of inoculation, but no glandular swelling, and is now (22 days after) alive, but not quite well. The 17 subcutaneously inoculated animals which died, were 4 rabbits, 10 guinea pigs, and 3 mice. The 5 inoculated by the intestinal tract and killed, were 1 monkey and 4 guinea pigs.

The death of the 6 cases that were not inoculated is to be attributed to some of them being purposely kept in cages in which plague animals had already been, and which had not been cleaned and washed in carbolic acid solution, as usual. The monkeys were kept under the cages of the other animals, so that food, urine, and feces were freely allowed to bespatter their cages. Death occurred in the rabbits and guinea pigs in from 2 to 6 days after inoculation.. One monkey died in 5 days, the pig in 22 days, the mice in from 22 to 48 hours.

Remarkable points are, that in all the cases of subcutaneous inoculation, the tissue around the spot of abdominal incision was infiltrated and from there to the glands of the axilla and groin lymphangitic cords could be seen as in human cases. The glands in the mesentery were swollen in nearly all cases.

The cases dying after feeding with plague tissues or pure cultures, showed diarrhea. In 1 pig and 1 monkey the stomach and intestine showed suggillation, catarrh, and swelling of the mesenteric glands as well as of external glands.

These observations justify the opinion that the plague can enter the body: (1) By the skin. (2) By the intestinal tract.

There were no cases in this epidemic, that were seen, where signs of inflammation round wounds were evident, and there are only 2 cases reported in Hong Kong, by Dr. Lawson and Dr. Aogama, in which plague with lymphangitis from cutaneous wounds occurred—the case of Dr. Aogama himself and Nakahara, but even here the opinions and reports differ. But as inoculation is undeniably successful, the possibility certainly exists.

Infection by the stomach is possible, as 56 of the cases operated upon by feeding experiments succeeded. This percentage means much more than the experiments by implantation or by inoculation, and approximates closely to the natural conditions of life—in fact, it gives a method of infection without artificial means. We may thus argue that in many cases where the plague bacillus reaches the intestinal tract, the disease may attack the body. This possibility is proved by the above experiments. Whether the healthy stomach is able to digest these germs can only be answered after more animal experiments have been carried out.

108 Stockton street.

AN UNUSUAL CASE OF PERITYPHLITIS.

By **George Franklin Shiels**, M.D. (Edin.), F.R.C.S. Ed., Associate Professor of Surgery, Medical Department, University of California, San Francisco.

Read before the San Francisco County Medical Society.

J. D——, æt. 43; American; married; attorney by profession Has always enjoyed good health, and has passed several life insurance examinations. On August 20, 1895, he went to Nevada to try a case into which he threw all his energy. The trial finished, he went in for a hard day's hunting, from which he returned much exhausted, and immediately came to San Francisco, and from there to Belvidere, where he arrived on the 29th.

On that day he was taken with violent, sharp, shooting pains in the right iliac region; there was complete obstipation but no vomiting. Dr. Bazan, who resided near by, was called in, and after a careful examination diagnosed perityphlitis. He put on a fly-blister, 4 by 6 inches, and ordered a mixture of chloral and morphine. Three days later, I being Mr. D.'s family physician, was called. I found the patient in great pain, his temperature was 104° F., pulse 100. The large blister made a careful examination impossible, but one could make out some fulness and resistance over the cecum, and there was general tenderness over the whole of the lumbar and iliac regions on the right side. As the constipation still persisted, castor oil and an enema were advised, with good effect. For a time the patient was relieved, but the pain returned and was more severe than before. The question of operation having arisen, it was thought wise to remove the patient to St. Luke's Hospital. This was done on September 10th.

On entering the hospital his temperature was normal and his pulse extremely slow, ranging between 50 and 60. As the pain in the iliac region continued, and the tendency toward constipation remained, a large poultice was placed over the lower part of the abdomen, and castor oil and enemata continued. At this time the pain became more general, extending over the whole right side, from the axilla to Poupart's ligament and from the middle line anteriorly to the lumbar region. The patient seemed to be growing weaker.

There was a certain difficulty on taking a deep breath, and physical examination showed some flattening in the pitch of the notes, and loss of the respiratory murmur over the base of the right lung.

A consultation was called, at which Drs. Bass, R. A. McLean, and J. F. Morse were present. It was decided that the perityphlitis had undergone resolution, but that there was present a latent pleurisy on the right side, and the question of there being a tubercular element in the case was canvassed. By general concensus of the consultants, a mustard plaster was placed over the dull area, and was followed by the use of the cotton jacket. The patient asserted that he felt much better, and returned home on October 8th, to Belvidere. He was ordered tonics, and came over to my office frequently for examination.

The dulness over the base of the right lung continued, the temperature ranged from between 99° to 100°, there was a catching of the breath on any effort at deep inspiration, and the patient seemed to be failing steadily, so much so, that though there had been no rigor or other indications of the formation of pus; still, taking into consideration the suspicion of tuberculosis and the persistent dulness, it was thought wise to make an exploratory aspiration. This was done on the 28th of October, at Belvidere. The needle was introduced between the ninth and tenth ribs, in the scapular line, when the presence of pus was at once made evident.

On the 29th of October, the patient again went to St. Luke's Hospital, and on the 30th was operated upon. Drs. Kenyon, Rachel, Johnstone, and Bass being present. A U-shaped flap was raised over the ninth and tenth ribs, and about 1½ inches of both ribs resected. What was thought to be the pleura was incised at the point where the needle had been introduced, but no pus escaped. I was somewhat surprised, not to say taken back, but feeling certain of the presence of pus, I took a hypodermic syringe, and on the basis of the diagnosis of pleurisy, introduced it in a somewhat upward direction, but still failed to find pus. It was then directed downward and forward, and upon being forced in for fully an inch and a half, some bloody pus appeared in the barrel of the syringe. Following the needle the incision was enlarged, when there gushed forth a quantity of curdy, sanious pus, which had a very foul odor. The opening was enlarged by a boring motion of the finger, and one could feel a large cavity which was evidently behind the ascending colon, since the fingers in the cavity could be palpated from the lumbar region. After thorough irrigation, two large drainage tubes were introduced, one slightly larger than the other, some loose packing of iodoform gauze placed around them, and the remainder of the wound sutured.

The patient was placed in bed in all but a moribund condition. The pulse was 50 and scarcely palpable; the temperature between 94° and 95°; the skin cold and clammy and the breathing shallow. Hypodermic injections of strychnine, alcohol and ether were freely administered, and all the usual methods employed to counteract the shock. He soon began to react, and by 8 o'clock in the evening we felt that he was out of immediate danger. From this on, nothing of note occurred. The wound was dressed and the cavity irrigated regularly. The tubes were gradually shortened, and on the 10th of December patient left the hospital.

He tells me that for a month after the operation he gained a pound a day, and that he is now heavier than he has been for 10 years. He feels perfectly well, were it not for a slight dragging over the wound on deep inspiration, which is no doubt due to adhesions and which may in time disappear.

The points which seem to me to be of particular interest in the case are the following:

1. The fact that neither Dr. Bazan nor myself were at any time able to locate any point of maximum tenderness at the McBurney point, which has been held to be of specific diagnostic import in cases of appendicitis. To my mind it has been entirely too forcibly urged as a specific sign, in so far that in nearly all the cases I have seen the pain has been much more general, and in some where the appendix was unquestionably the seat of the disease the point of maximum pain has been to the left of the middle line.

2. With all proper respect for the high ability of Dr. Bazan, I would urge that the use of blisters is contraindicated in cases of this nature, and for the following reasons: (*a*) it masks the symptoms; (*b*) it makes a careful examination impossible; (*c*) in cases of operation the incision would have to be carried through an infected area, which could not be antiseptically prepared without the causation of great irritation which would interfere with the after-treatment. In a case upon which I operated some years ago, stitch-hole abscesses followed and the dressing was rendered difficult and painful.

3. It is interesting to note, that though we had to deal with a marked inflammation around the cecum, and the consequent formation of a large abscess containing more than a pint of pus, there was at no time any indication through the temperature or pulse that would point to the actual condition if we exclude the high temperature for the first two or three days of the disease.

4. It is worthy of note that this case proves it possible for a man to be up and about with a large abscess cavity, extending from the cecum to nearly the tenth rib without having symptoms more severe than those just described.

5. The case just reported adds another to the list in which abscesses arising in connection with one or the other of the abdominal organs, by encroaching upon, opening into or displacing the pleura, have led to a mistaken diagnosis, and the belief that the condition was thoracic rather than abdominal in its nature. I might say in this regard that there could be no mistake as to the origin of the trouble in this case, both from the history and the further fact that at the time of the operation I could pass my finger, which is unusually long, well down behind the liver to nearly the length of the cecum. I could feel the soft movable colon in front and could palpate my finger, with my other hand, through the muscles of the back.

108 Stockton street.

PRACTICAL METHODS OF DEMONSTRATING TUBERCLE BACILLI.

By W. N. Sherman, M.D., Merced, Cal.

Read before the San Joaquin Valley Medical Society.

When we consider the rapid progress of medical science, we must realize the vast field of literature with which the general practitioner should familiarize himself, in order to keep posted. With such conditions confronting us, we must economize our time and adopt methods, that are shortest and quickest, in enabling us to reach conclusions and to obtain results. For this reason the tendency of the science of bacteriology is to teach methods by which we can most quickly reach results, and thus make a quick and sure diagnosis of contagious and other diseases. In such diseases as cholera and diphtheria, a skilful bacteriologist may, within 24 hours, establish a positive diagnosis, by means of the microscope. In cases of tubercular disease of the lungs, a positive diagnosis may be established in fifteen minutes, when the most careful and skilful physical examination may have failed to reveal the slightest lesion.

The various methods of examining sputa for the tubercle bacillus would only seem to confuse the beginner, unless he had ample time at his disposal. Numerous modifications of the original Koch-Erhlich method have been recommended and adopted, the constant aim being to simplify and shorten the *technique* without detracting from its reliability. Biedert has recently recommended the following method for demonstrating the bacilli when they are scant in number. A teaspoonful of sputum and two teaspoonfuls of water are boiled with 15 drops of solution of caustic soda, then four teaspoonfuls of water are added and the whole again boiled until it forms a homogenous fluid. It is allowed to stand for two days (not longer) in a conical glass, when the bacilli and elastic fibers form the sediment, which is to be stained by the Ziehl-Neilson process. When one is not accustomed to examine for the bacillus tuberculosis, for the purpose of controlling the degree of staining, he should, at the same time, stain some sputum that is known to contain the bacillus, or else keep a few test slides on hand.

Another method of preparing the sputum, is the method of Dahnen: the sputum, contained in a vessel, is heated (not boiled) in boiling water, thus precipitating the solid substance and the bacilli, which can be examined at once. The digestive method is a substitute for the Biedert method, and is superior in many respects. The sputum is introduced into a test tube, and the digestive fluid added, which is 1 per cent. of hydrochloric acid containing pepsin. The test tube is then placed in an incubator or water bath, at a temperature of 98.6° F. for an hour, when it is removed, shaken, and allowed to sediment. Before spreading on the cover glass the fluid must be rendered alkaline by adding a drop or more of caustic potash. The staining is done in the usual way.

It is best for the beginner to choose a simple and easy method of staining, and to stick to the one method, as by constant practice he becomes more skilful. It is always best to prepare a number of slides from each specimen, as some of them may fail to show the bacilli. The simplest and quickest method of staining is that of Gabbet, and it requires but two solutions, which may be preserved for months. The cover glass, prepared and dried in the usual way, is placed for two minutes in a solution of 1 part of fuchsin in 100 parts of a 5 per cent. solution of carbolic acid, and 10 parts of absolute alcohol. It is best to warm this solution. The cover glass is next removed from this solution, rinsed in water, and placed for one minute in a solution of 2 parts of methylin blue to 100 parts of a 25 per cent. solution of sulphuric acid. It is again rinsed in water, then in alcohol, and dried and mounted in balsam. The preparations made by this method are very beautiful and permanent.

The method which I employ is that of Pittion and Roux. With this, more time is required, and more skill in manipulation; but when skilfully used, the bacilli are larger and more distinct than by any other procedure. Three solutions are used, and all should be fresh except the first. Sol. *a* is 10 parts of fuchsin in 100 parts of absolute alcohol. Sol. *b*, 3 parts liq. ammon. in 100 parts distilled water. Sol. *c*, alcohol 50, water 30, nitric acid 20, aniline green to saturation; dissolve the color in alcohol, then add the water and next the acid.

To use, take of *a* 1 part and of *b* 10 parts, heat until vapor appears, and float cover glass in usual way for about two minutes, then rinse in distilled water, and place in solution *c* until the red color disappears, then wash and mount. It takes some experience to know just how much to decolorize.

The tubercle bacilli are distinctly recognized by their red staining. With a good specimen and careful staining by this method the bacilli appear as large under a dry $\frac{1}{5}$ objective as under a $\frac{1}{10}$ immersion objective by other staining processes. Their presence in the sputum is a sure indication of tuberculosis of the lungs or larynx. Quite a close approximation of the severity of the disease may be made by the number of bacilli, but more closely by the quantity of the spores. Bacilli are often discovered when the physical signs are still indistinct or altogether wanting. Absence of the bacilli at a single examination is without value.

These slides [specimens exhibited] are stained by the two methods last mentioned, and are from the sputum of a patient under treatment with Edson's aseptolin since February 22, 1896. The expectoration has continually decreased in quantity, but there seems to be little effect, if any, upon the form and number of the bacilli.

CARDIAC DYSPNEA AND CARDIAC ASTHMA.

By A. W. PERRY, M.D., San Francisco, Cal.

Read before the San Francisco Medico-Chirurgical Society.

By these terms are meant a dyspnea that does not depend on any organic disease of the lung, or pleura, or an obstruction of the air passages; it must depend on a functional or organic disease of the heart. The difference between cardiac dyspnea and cardiac asthma is that the first arises during moderate exertion, and the last occurs during rest, without obvious cause, and is more severe. As they both have a common cause to a great extent, I will consider them together.

In health about $\frac{1}{700}$ of the total amount of the blood in the body is expelled from the left side of the heart at each beat, and an equal amount is driven from the right heart into the lungs. If the right heart drives more blood into the lungs than is received from the lungs by the left heart, and driven out into the greater circulation, an active congestion of the lungs is produced, which causes a rigidity of the lung tissue similar to the hardening of the erectile tissues. This rigidity of the lungs prevents them from expanding freely with the inspiratory expansion of the chest wall, and a dyspnea is produced, which is called cardiac, because the disordered action of the heart has caused the high blood pressure in the lungs. It is a dyspnea, or an asthma, according as it occurs during exertion or during rest. It is probably the most common mechanism of all dyspneas not due to lung disease. It was formerly accepted that in congestion of the lungs there was a passive stasis of imperfectly oxydized blood, and that the presence of this blood highly charged with carbonic acid circulating in the respiratory centers caused the dyspneic sensation and movements.

In 1887, S. von Basch, of Vienna, claimed that the dyspnea was due to rigidity of the lung tissue from increased blood pressure; this he proves as follows: The lungs and heart were removed from an animal, a bellows inserted into the trachea, which was also connected with a manometer; at the same time the pulmonary artery was connected with a vessel of water under pressure, and also with a manometer. He found with each compression of the bellows a certain distension of the lungs, which was constant with equal pressures in the pulmonary artery; when the pressure in the pulmonary artery was increased the same compression of the bellows produced less distension of the lungs.

To show that the increased amount of blood in the lungs did not diminish its capacity for air, he found that a manometer connected with the trachea of a collapsed lung showed a diminishing pressure, as liquid was forced into the lungs through the pulmonary artery. A high blood pressure in the lungs did not diminish the amount of air in the lungs, but it did diminish their expansibility to inflation through the trachea.

From experiments on the lungs of dead bodies made by Donders, and on living animals by Adamkiewicz and Jakobson, it was found that the lungs of the dead body exercise on the closed chest-wall a traction which equals the pressure of 7½ millimeters of mercury. In the living animal this traction is much less, viz: 3 to 5 millimeters of mercury. The difference is due to the lungs of the dead animal being nearly empty of blood.

I recently found an additional evidence of the lung rigidity in a patient affected with Bright's disease, a passive exudation into both pleuræ, general arterio-capillary scleroses, and a pulse of high tension. He had frequent attacks of cardiac asthma; as the liquid in the pleural increased I drew off the effusion several times, with immediate relief to his difficult breathing, the relief lasting from 4 to 10 days. After the fourth removal of the fluid, I noticed the attacks of dyspnea would occur as bad as ever within eight hours after emptying the chest. The intercostal spaces were also much retracted at each inspiration; showing that the lung did not expand to fill the space left by removal of the fluid. As there was no evidence of any adhesions, this could only have been caused by a lung rigidity due to the high blood tension of the Bright's disease.

Valvular diseases of the heart and great vessels exist for years without the occurrence of dyspnea. This shows that each side of the heart, and probably each cavity, is controlled by separate nervous centers, which maintain the blood pressure in the lungs at or near a certain comfortable point, of course with the aid of the vasomotor nerves of the pulmonic vessels. If this regulating action did not exist dyspnea should occur in the earliest stage of any valvular disease of the left heart, or great vessels which obstructs the outward flow of blood from the left heart.

In the beginning of a mitral regurgitation the volume of blood expelled from the left heart at each beat being say $\frac{9}{10}$ of the normal quantity, as long as there is no dyspnea, the right heart must also send into the lungs $\frac{9}{10}$ of the normal quantity, and this must be regulated by the nervous centers for each side of the heart. With the right side healthy, and delivering into the lungs the normal quantity, and the diseased left side sending out from the lungs $\frac{9}{10}$ the normal quantity, an active congestion and a rigidity of the lungs would quickly occur. This control may be assumed to last a long time, and constitutes a compensation. This control also implies an excessive action of the nervous centers, and must in time lead to their exhaustion; the lungs then become distended and rigidity-dyspnea occurs. Other causes than exhaustion of the cardiac nervous centers may prevent the harmonious action of the two sides of the heart; amongst these are probably reflex influences.

When the control above mentioned ceases from obscure reflex influences, or from the excessive irritability of exhaustion, some sedatives, especially small doses of morphine, will give relief to the dyspnea for many months or years. The morphine acts probably by allaying the irritability of the nervous centers, and by preventing injurious reflex influences from disturbing the cardiac controlling centers.

The great benefit of morphine in these cases has long been known, but its use has been entirely empirical, and it is generally employed in severe cardiac dyspnea as a last resort, and with a dread of evil effects. S. von Basch says that morphine may be given in cardiac asthma and dyspnea without fear when the pulse is full and the blood pressure is high. This limitation is too narrow, and would exclude it in the cardiac asthma of mitral and aortic regurgitation, in which the pulse is not full nor the blood pressure high, and yet we find that morphine gives great relief in such cases.

One of the most distressing cases of this cardiac asthma from lung rigidity died under my care six months ago. A woman, 64 years old, had had mitral regurgitation for many years. There was no cyanosis or swelling of the neck veins or of the limbs, but great dyspnea on the slightest exertion, and often without any exertion. There was no tension in the pulse; during inspiration there was sinking in of the supra-clavicular fossæ, the supra-sternal notch, and the intercostal spaces. There was also a constant severe pain like angina pectoris. For years before her death small doses of morphine gave her considerable comfort, and enabled her to support herself.

I offer some additional signs of lung rigidity-dyspnea, and indications for the use of morphine therein. When in cardiac asthma or dyspnea the intercostal and supra-clavicular spaces are deeply drawn in, and there is no obstruction of the air-passages by fluid, spasm, or tumors; there must be lung-rigidity. If the large cervical veins are not distended and pulsating there can be no great blood stasis in the lungs. When these signs are present morphine in small doses $\frac{1}{8}$ to $\frac{1}{4}$ grain, two or three times daily, is a safe and most efficient remedy. If there is edema of the lungs, or distension and pulsation of the cervical veins, morphine will do harm. Of course there are other means which will reduce general blood tension and so relieve the high blood tension in the lungs on which this rigidity-dyspnea depends, viz: alkalies, nitro-glycerin, and other nitrites, reduction of body weight, etc., but none act so well and so long as morphine.

207 Turk street.

TOTAL EXCISION OF THE LEFT SCAPULA FOR OSTEO-SARCOMA; RECOVERY WITH USEFUL ARM.

By George Childs MacDonald, M.D. (Brux), F.R.C.S., Ed., etc., San Francisco, Cal.

E. B——, female, age 24, native of the Western Islands, consulted me about the end of February, 1895, for a large swelling over the left scapula, and loss of motion of the corresponding arm with wasting and general weakness. She gave the following clinical history: About 7 months previous she had one night been awakened by a pain corresponding to what would now be the center of the swelling;

the pain continued from that time with an increasing swelling over the painful region. Patient went to several medical men, and various treatments with liniments and plasters had been tried.

On examination, the tumor presented a smooth, dome-faced surface, solid in parts and semi-fluctuating in others, with egg-shell crackling. Over the upper and outer extremity it was somewhat inflamed due to a puncture which had been made for diagnostic purposes. The head of the humerus was, apparently, displaced inwards, but this was due to the rotation and bulging of the scapula, the head being really in the glenoid cavity—the arm could not be moved from the side and was a useless appendage. The diagnosis of osteo-sarcoma was made, and patient advised to go into hospital and have the scapula removed. The reason I did not favor the more radical procedure of removal of the arm and scapula was based on my diagnosis, viz: that the scapula only was implicated, the growth being confined within bony limits.

January 30, 1896, patient was admitted to hospital, and on the following day the operation was performed. The incision extended from the acromio-clavicular articulation downwards along the axillary border of the scapula, a horizontal incision extending from the root of the spine to the axillary border, meeting the vertical incision at right angles. The superior skin-flap was dissected up and disarticulation performed at the juncture of acromion with clavical. The inferior flap was then dissected downward and inward until the vertebral border of the scapula was reached. The rhomboid muscles, elevator of the angle, and serratus magnus were then divided and the bone drawn away from the back, the knife being kept well on the subscapularis. The tumor was now readily lifted out, the subscapularis supra and infra spinatus, together with the teres major and minor, were severed at their level with the shoulder-joint, the capsule of that joint incised, and the whole mass removed. Hemorrhage was slight and quickly controlled by ligature. Both the glenoid cavity and head of the humerus were free from disease. About 1½ inches was removed from the outer end of the clavicle in order to make the shoulder a better shape. Two large drainage tubes were inserted and plenty of hot water used to stop general oozing. The flaps came well together, and the wound was dressed with the usual antiseptic precautions. The growth, after removal, measured 7½ by 8½ inches.

The patient did well for the first 14 days, having no rise in temperature. The operation wound having healed by first intention, at that time for some reason due, no doubt, to insufficient care on the part of the dresser she became septic. Some pus appeared in the drainage tube, and she had a rise of temperature for about ten days. Free irrigation with bichloride solution (1:5000) was used several times a day. The wound now quickly consolidated, and the patient left the hospital in good health, having gained in flesh during the latter portion of her stay. She has since reported at my office several times, and is getting good motion in the arm, a false joint having formed. There is no evidence yet of any return, and she has recovered her usual weight.

The interesting points in this case are the apparent (to the patient) suddenness of invasion of the disease, which can be accounted for by a rupture of some small cyst in the interior of the tumor during its incipiency. The small amount of hemorrhage during the operation, and the absolute localization of the growth to the scapula, are also noteworthy. It had commenced between the two plates of the body of the bone, which had expanded so that they formed a complete thin bony wall to the large and many cysts, making up the center of the neoplasm. In this way the surrounding tissues had escaped contamination.

32 O'Farrell street.

DEPARTMENTS.

OBSTETRICS, GYNECOLOGY AND PEDIATRICS.

By WALLACE A. BRIGGS, M.D., Sacramento, Cal., and

WM. FITCH CHENEY, B.A., M.D., Adjunct to the Chair of Obstetrics and Diseases of Women and Children, Cooper Medical College, San Francisco, Cal.

Making and Closing the Celiotomy Incision.—GEORGE M. EDEBOHLS, of New York, says he has given up trying to make the celiotomy incision exactly in the median line, between the recti muscles, and by choice makes it through one of the recti muscles, a little to one side of the median line. He believes that he thus gets a stronger cicatrix after closure of the wound, by the union of bare muscle surfaces. If he has by chance hit the median line exactly, not exposing any muscle, he deliberately, before closing the wound, splits the sheaths of the recti on both sides by incising them along the entire length of the wound. Edebohls has given up the use of silkworm gut for buried suture in closing the abdominal incision in separate layers. The objection is the not infrequent occurrence of sinuses leading down to the buried suture weeks or months after the operation, that close only after resurrection of the buried stitch. Instead of silkworm gut he advises the use of chromicized catgut so prepared as to maintain its integrity for about six weeks, and then to disappear by absorption.—*American Gynecological and Obstetrical Journal*, May, 1896.

Treatment of Ectopic Pregnancy.—Aside from hematocele proper, which should be reached by the vagina, PICQUÉ distinguishes two classes of ectopic gestation: (1.) Tubal pregnancy attended with grave danger of rupture into the peritoneal cavity. Either celiotomy or colpotomy may be performed, as seems preferable in the individual case. (2.) Peritoneal pregnancy. Here, naturally, celiotomy should be done, but when? The mother takes precedence of the fetus, and if her health suffers, celiotomy should be done at once; but if pregnancy be well borne we may delay until the seventh or eighth month with the hope of delivering a living child. In regard to the placenta the *technique* of Pinard should be followed—leaving the placenta and promoting its aseptic elimination. Reynier contends that intervention should always be *per abdominum*—never *per vaginam*. Routier believes that colpotomy is justifiable when the fetal sac is easily accessible from the vagina. Segoud emphasizes the difficulties of diagnosis and believes it best always to intervene before the fifth month. In uncomplicated cases he operates *per abdominum*; in hematocele *per vaginam*, even after repeated hemorrhages; if suppuration occurs, he does vaginal hysterectomy.—*Révue Medicale*, February 2, 1896.

SURGERY AND ANATOMY.

By T. W. HUNTINGTON, B.A., M.D., Surgeon Southern Pacific Company's Hospital, Sacramento, Cal., and

GEO. B. SOMERS, M.D., San Francisco, Cal.

To Prevent Hemorrhage.—In the course of a description of a case of lymphosarcoma of the left side of the naso-pharynx, MR. WATSON CHEYNE makes the following note: "Just at the time that this case occurred Dr. Wright had published some papers on the value of chloride of calcium in increasing the coagulability of the blood, and also of fibrin ferment as a styptic, and I therefore asked him to be present and to superintend the use of these substances, for I anticipated that there would be a good deal of bleeding. Accordingly, an hour before the operation a pint of water containing half an ounce of chloride of calcium was injected into the rectum, and during the operation pledgets of salicylic wool, soaked in Wright's fibrin ferment solution, were applied to the freshly cut surfaces. Whether as the result of this treatment or not, the fact is that extremely little blood was lost; I do not think more than an ounce or an ounce and a half."—*Lancet*, February 22, 1896.

Administration of Oxygen with Anesthetics.—In an article on this subject, DR. LAW, of Minneapolis, calls attention to the numerous cases where, after an anesthetic has been administered, chronic symptoms arise. He notes the physical depression sometimes occurring in children and lasting for weeks, the invalidism of anemic women, and the depression of vital forces, such as irregular heat, gastric and nervous troubles, kidney lesions, etc., all traceable to the same cause. It has been shown that chloroform destroys the power of hemoglobin to absorb oxygen resulting in general malnutrition. Ether has a similar effect. To obviate these and other effects, it is proposed to administer oxygen at the same time as the anesthetic. Dr. Law uses an apparatus suggested by Dr. H. L. Northrop, of Philadelphia, and made by Lentz & Sons, of the same city. It consists of a small steel cylinder holding 40 gallons of pure oxygen, enough to last for 4 to 6 hours, a small wheel for controlling the pressure, a graduated 2-ounce bottle with tubulatures (similar to a Wolf's flask), the requisite length of tubing, and a metallic inhaler, protected by a pneumatic rubber shield that makes the flask fit snugly to the patient's face. With the use of the oxygen, nausea and vomiting are rare, patients awake in from 10 to 15 minutes, and almost invariably without delirium or intoxication.—*Northwestern Lancet*, June 15, 1896.

The Technique of Mannsell's Method of Intestinal Anastomosis.—The portion of intestine to be excised is emptied of its contents above and below the diseased part, by passing it between the finger and thumb and greatly compressing it. The empty gut is then clamped on either side of the diseased portion at points 6 inches distant. The portion of intestine to be removed is excised by a V-shaped incision, which has its apex in the mesentery. The divided ends of the intestine are washed with a hot saline solution, followed by a small quantity of a 15-volume solution of hydrogen peroxide, and the proximal and distal ends are united primarily by means of two temporary sutures, the first placed at the mesenteric border and the second directly opposite at the highest point of the superior border. These are tied and left with long ends. A longitudinal incision, an inch and a half long, is next made in the superior border of the larger intestinal segment, two inches from its severed end, by pinching up the intestinal coats between the finger and thumb, and dividing them with a narrow-bladed knife. The long ends of the temporary sutures are caught up and drawn through the opening until the ends of the segments of the bowel are invaginated and made to appear through the incision as concentric rings. The ends of the long sutures are then held by an assistant while the sutures, 20 in number, are placed and tied. A fine straight needle armed with horsehair is used, and is passed through all the coats of the bowel and through both sides about a quarter of an inch from the divided ends. The suture is caught up by forceps, divided in the middle, and tied at once on either side. The temporary sutures are then cut off, the cut ends of the bowel are dusted with iodoform or acetanilid, and the invaginated portion is reduced by means of gentle manipulation, accompanied by slight traction. The edges of the longitudinal opening are turned in, and it is closed by Lembert sutures passed through the peritoneal muscular and submucous coats.—*New York Medical Journal.—International Medical Magazine*, March, 1896.

OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

BY WM. ELLERY BRIGGS, M.D., Sacramento, Cal.

Precision in Squint Operations.—DR. MAXWELL reports 168 cases of convergent squint and discusses precision in squint operations. Seventy-one per cent. of these cases occurred before the age of 3 years, and the average refraction of each eye was +3 D. The average amount of squint measured in angles by the perimeter, was 30°. In 57 cases a single tenotomy was performed, which reduced the squint on the second or fourth day after the operation, by 17.5°. When tested again, on the fourteenth day, the reduction was found to be about 15°. When the second eye was subsequently tenotomized, the final reduction was found to be greater than the primary. The author then described a new method of operating, for which a special instrument was necessary, which showed, on a scale, how much the tendon was raised from the globe, and was intended to indicate, during the operation, how great a shortening might be anticipated. The amount of squint that an eye should have when entirely due to hypermetropia, was 3° for each diopter. The author said that he allowed 5° of squint to remain after the operation.—*Medical News*, August 29, 1896.

The Operative Treatment of High Myopia.—MR. LAWFORD, in a paper on the operative treatment of high myopia, states that eyes with less than 11 D. or 12 D. of myopia, were unsuitable cases for operation. The use of the method should be governed, in a large degree, by the health, social environment, and duties of each patient, as well as the condition of the eye itself. Van Hippell has reported cases of successful operation upon eyes presenting 35 D. to 50 D., and it might, therefore, be concluded that there was no limit to the degree of error suitable for the method, provided the condition of the eye itself is favorable. In the lens extraction he had abandoned the preliminary iridectomy, as the circular pupil was more important in these cases than in those of senile cataract. Only 4 out of 68 cases operated upon gave an unfavorable result.—*Medical News*, August 29, 1896.

The Indications for Perforating the Mastoid in Acute and Subacute Middle-Ear Inflammations.—DR. FELIX COHN discusses the indications for perforating the mastoid in acute and subacute middle-ear inflammations, and arrives at the following conclusions: The presence of hyperemia and congestion alone is no indication for opening the mastoid. The mastoid should be opened in all cases of osteitis, if, under the usual antiphlogistic treatment, the inflammation shows no tendency to resolution. In pronounced cases of antral empyema, in which the character of the discharge is prevalent and the empyema shows no tendency to discharge completely through the middle ear. In all cases of protracted otitis with profuse otorrhea, which show no tendency to resolve within a reasonable period, the time chosen for operation depending upon the manifest symptoms, whether, for instance, retention is present or the mastoid bone itself is involved. In every case of acute otitis in which there are dangerous symptoms of resorption, and in which the drainage cannot be established by paracentesis or by the natural perforations. In those cases, even without manifest symptoms of mastoid affection, the mastoid should be opened, in order to produce a more favorable drainage and to enable a thorough cleansing of the middle ear. In all cases of muco-purulent otitis in which the otitis is evidently maintained by mastoid involvement, the time for operation depending upon the condition of the patient and the presence or absence of symptoms pointing to retention or other complications of a serious nature. In cases of mastoid disease, or otitis complicated by lymphangitis or lymphadenitis, in which there is imminent danger of the formation of an abscess, and in those cases in which the lymphadenitis does not tend to resolve under ordinary antiphlogistic treatment. In cases of protracted otitis, in which there are symptoms of serious secondary complications, involving danger of extension of the inflammation inward toward the brain, or downward toward the neck. In cases of acute otitis, in which complicating stenosis of the external canal prevents drainage and thorough cleansing of the middle ear.—*New York Medical Journal*, August 8, 1896.

DERMATOLOGY, SYPHILIS AND VENEREAL DISEASES.

Etiology of Acne.—LOMRY (*Dermatolog. Zeit.*, August, 1896), arrives at the following conclusions regarding the etiology of this disease: (1) The staphylococcus pyogenes albus is constantly found in the acne pustule. (2) This staphylococcus has a very weak virulence. (3) In the passages of the body it may be made as virulent as the most pathogenic yellow staphylococcus; at the same time it becomes yellow and acquires a decided power to liquify gelatine. (4) Besides the staphylococcus albus a yeast fungus and a small bacillus are met, but always in trifling numbers. (5) In the non-inflammatory comedo is found a very rich microbe development which always contains the staphylococcus albus, but without that preponderance which exists in the acne pustule.

(6) In the comedo one observes at the beginning of the inflammatory process an intermediate microbe development between that of the pustule and that of the non-inflammatory comedo. At the instant that inflammation is set up in the comedo there takes place an important simplification of the microbe growth. (7) The skin of the individual unaffected with acne is just as rich in microbe colonies as that of one who is so affected. (8) In the comedones and pustules, which sometimes come to those who do not have acne, the same microbes are observed as in those who suffer from the disease (9) The presence of certain microbes does not suffice to explain acne; a prepared soil is also necessary. (10) A specific acne germ need not be assumed. It is a fact that the staphylococcus albus is observed in many other skin affections. (11) The clinical events which Unna cites as distinguishing acne from other staphylococcic infections of the skin may be explained in a natural manner by the difference in the virulence of the microbes. (12) Unna's special bacillus is a slightly virulent variety of the bacterium coli.

Urticaria.—DR. GILCHRIST reports a case of urticaria pigmentosa, a very rare disease of the skin, in a child of 17 months. From experiments on excised wheals, both spontaneously and artificially produced, the following observations are recorded: (1) The wheals produced artificially in urticaria are certainly inflammatory. (2) Spontaneous wheals in other cases of urticaria have been found to show all the factors constituting inflammation. As to how the inflammation is produced when a finger nail is drawn over the skin without injuring it, Dr. Welch suggests that there is a toxemic condition of the blood in patients suffering from urticaria, and when the skin is stimulated, some of the toxine is set free into the tissues of the skin, and thus sets up inflammation. (3) Mono-nuclear leucocytes are capable of leaving the blood vessels quickly and in considerable numbers in certain affections of the skin. This fact is not generally admitted. Dr. Flexner remarks: "Pathologists have come more and more to regard the view that the polymorphonuclear cells alone leave the vessels in inflammation as insufficient; they have, however, regarded them as the earliest to escape in numbers.—*Johns Hopkins Hospital Bulletin*, vol. vii, No. 64.

MATERIA MEDICA AND THERAPEUTICS.

By WM. WATT KERR, M.A., M.B., C.M., Professor of Clinical Medicine, University of California, San Francisco.

Injections of Ass's Serum in Malignant Disease.—ARLOING and COURMONT report (*Bull. de l'Acad. de Méd.*) the results of a number of experiments on the therapeutic effect of injections of ass's serum, normal or previously inoculated with epithelioma juice, in patients suffering from malignant tumors. Their conclusions may be given in their own words: (1) Injections of ass's serum, previously inoculated with epithelioma juice made in the human subject in the neighborhood of malignant tumors, are incapable by themselves of bringing about the disappearance of these tumors, or even of preventing their generalization and the fatal issue of the disease. (2) They may, nevertheless, be useful by inducing a momentary diminution in the size of the tumors, probably by a regression of the peripheral inflammatory zone. This action may be the starting point of a cure by rendering operable a tumor which was inoperble before the injections. Most frequently it will cause a momentary disappearance of the symptoms of compression—pains, edema. The general evolution of the disease will sometimes be checked for several weeks. (3) Ass's serum so prepared has seemed to us to contain toxic substances which do not exist in equal quantity in normal ass's serum. These substances accumulate in the organism or predispose it in such a manner that at a given moment they produce (at least in cancerous subjects) reaction symptoms (edema, purpura, various eruptions, etc.), about the site of puncture, or even at a distance. these symptoms appear on an average after the fifth injection, and at an interval of time nearer to the puncture in proportion to the time that has elapsed since the beginning of treatment; they disappear at the end of some hours or some days. They are frequently accompanied by constitutional symptoms (elevation of temperature, anorexia, insomnia, etc.). About the fifteenth injection the patients refuse to go on with the treatment. (4) With normal ass's serum we have obtained the same shrinkage of the tumors without ever noticing reactive phenomena comparable to the preceding (at the seat of injection). (5) Consequently we think that one may try subcutaneous injections of serum in the vicinity of inoperable tumors when these might become operable after changes in the neighboring parts, or when they are accompanied by pain or edema due to compression. Normal ass's serum will be employed in preference to ass's serum previously inoculated with epithelioma juice. At the recent meeting of the Société de Dermatologie et de Syphilographie, Augagneur (*Sem. Méd.*) reported the results of some experiments of the same kind made by him in cases of cancer and syphilis. In patients suffering from epithelioma of the skin he injected ass's serum in doses of 8, 10, and 12 cm. After the injection the tumor became turgid and bleeding, then after a time it diminished in size; this effect was, however, only temporary. He observed similar local phenomena after injections of serum in patients with simple vegetations. The injections have the same effect in persons suffering from lupus; after a period of edema and congestion there ensues a passing shrinkage. Formerly he tried the injections in syphilitic subjects. He made particular mention of one case of exuberant facial and lingual syphiloma, which was improved for a month. He makes the injections into the cellular tissue. Urticaria often occurs about the site of puncture, and there is some rise of temperature. On two occasions albuminuria occurred.—*British Medical Journal*, June 6, 1896.

MEDICINE AND PATHOLOGY.

By Albert Abrams, M.D., Professor of Pathology, Cooper Medical College, San Francisco.

Mechanical Support of the Lung in Phthisis.—The suggestion to strap the chest in phthisis is invariably met with the objection, that one of the objects in the treatment of that disease is to expand the chest and so call into play portions of lung which, in conditions of sub-active health, take little or no share in the respiratory process. In health, the respiratory capacity of the lung is commensurate with the semi-circumference of the thorax. The diseased lung may be regarded as decreased in bulk, so far as function is concerned, by the amount of lung tissue involved. It follows that the best mechanical condition of respiration will be secured by reducing the thoracic cavity in proportion to the reduced bulk of lung. In so far as the inflammatory element in phthisis is concerned, rest and relaxation of the inflamed tissues seem indicated and essential to the healing process. Comparative rest of the lung may be secured, according to Stuart Tidey, by keeping the patient at absolute rest day and night. This method has obvious disadvantages. The English school aims at developing the latent resources of the lung by promoting general nutrition. The author suggests strapping the chest in cases of phthisis. The advantages of strapping the chest are summarized as follows: (1) In early phthisis (catarrhal stage) to give comparative rest and relaxation to affected lung tissue. (2) In the stage of consolidation, to secure the same results, thereby limiting the risk of extension and to promote elimination of the diseased products by improving the circulation in and about the diseased area and to facilitate expectoration. (3) In the stage of cavitation, to promote closing of cavities by directing healthy lung to encroach on the diseased area instead of relying on natural processes of cicatrization. (4) Diminishing tendency to hemorrhage, by reducing tension on vessels and cicatricial traction on vessel walls. (5) The ultimate object is to obtain a smaller thoracic cavity filled with healthy lung instead of an enlarged thoracic cavity partly filled with diseased lung.—*British Medical Journal*, March 21, 1896.

Alkaloidal Poisoning.—The intestinal canal has, says DR. BUNCÉ, been always recognized as a factor in pathogenesis. Even in health the conditions are favorable to the growth and propagation of microörganisms. The stomach plays a less important role than the intestines in the production of alkaloids. Even peptone itself is a poison of no inconsiderable power. It has been shown that alkaloid products vary according to the stage of decay at which they are produced. At first the poisonous action of the ptomaines may be slight, but as decomposition advances the poisons become more virulent, while after a still longer period they become more broken up and lose to a greater extent their poisonous power. Normal digestion, depending as it does on the proper preparation, cooking, mastication, quality, a judicious combination of the food stuffs, the healthy metabolic activity of the numerous specialized glands, and the interdependence of their complex secretory products in their proper proportions, an adequate nerve and muscle tonus, mental relaxation or freedom from anxiety during and immediately following a meal, it is not surprising that these organs resent the frequent insults and produce the varied train of morbid phenomena so commonly met with, principally in women from the twenty-fifth to the forty-fifth year; and if carefully studied will exhibit symptoms that would seemingly fit the diagnosis: Peptone or alkaloidal poisoning. In the condition of atonic subacidity with diminished, or after a copious meal, a relatively insufficient secretion of hydrochloric acid, absence of its all-important functions (*i. e.*, maintaining the ingesta in an aseptic condition, and its proteolytic action on the acid and hemi-albumoses and pepsinogen developing them into their final products), the digestive act being prolonged leads to gastrectsia transient or permanent. The chemical reaction then present facilitates fermentation; imperfect peptones are formed, pass through the duodenum, mingle with a deficient quantity of perverted bile, are absorbed into the portal blood and introduced to a congested liver which may or may not be capable of neutralizing its toxic alkaloids. Among the more common symptoms that might be attributable to peptone, ptomaine or leucomaine absorption, are nerve depression, languor, drowsiness, vertigo, cephalalgia, nausea or vomiting, usually most marked during the acme of chyme absorption. Dyspepsias associated with pyrexia, vomiting, diarrhea, headache and abdominal tenderness which so closely simulate early typhoid fever. Among the dermic phenomena are urticaria, erythema simplex and multiform, angio-neurotic edema and general vaso-motor ataxia. The type possibly depending on idiosyncrasy, chronicity, and the degree of irritation reflected to the cutaneous vascular nerve mechanism. Neurasthenia and anemia will at times point to the intestinal tract as the probable *fons et origio mali.* Nerve and muscular pains about the shoulders, especially the deltoid, pleurodynia, digital nerves of upper extremities, manifest as a neurosis, anesthesia or parasthesia. Cases of the above type frequently coexist with the lithemic habit, though there are instances in which the gastro-intestinal disturbances stand out so prominently to the exclusion of the more characteristic signs of lithemia, *i. e.*, urinary, vascular, etc., yet with symptoms that are common to both, namely, the mental depression, drowsiness, vertigo, headaches, neuritic pains and myalgias. In the former the interesting question frequently will arise, Which symptoms are due to the absorption of the soluble toxins, and which are the result of the gradual accumulation and circulation of unoxidized waste products and uric acid? Lactic acid resulting from the activity of the penicilium glaucum, is said to be a muscle poison and to lessen the functional activity of the brain and cord. Its absorption and circulation may in part explain the pains and sopor usually present. The following is the course of treatment generally carried out in Dr. S. Solis-Cohen's medical dispensary: The necessary injunction as to diet, more or less strict avoidance of the fats, sugars, starches, of the abuse of alcohol, tea, coffee; curtailing it if necessary to milk plain or pancreatized, the latter not to be continued for any great length of time, administered in small quantities at frequent intervals, warmed, if in the cold state, it increase the discomfort. As the condition improves, boiled minced meats, red or white fish, and the farinaceous foods are gradually added. As constipation with a yellow-brown furred tongue and abeyance of the hepatic function are generally present, a preliminary mercurial purge is given, preferably the mild chlorid combined with powdered ipecacuanha or sodium bicarbonate; sodium phosphate is then used for a varying period, followed by a tonic cathartic such as the compound ignatia pill of the Polyclinic House Formulary. To maintain the canal in as clean a condition as possible, resort is had to antiseptics, the best being the phenol group. In the atonic, gastric catarrhs with flabby tooth-marked tongues, there may be given some such prescription as the following:

Tincture of nux vomica	15 minims.
Diluted hydrochloric acid or diluted nitro-hydrochloric acid	20 minims.
Essence of pepsin	½ fluidrachm.
Tincture of calumba sufficient to make	2 fluidrachms.—M.

Give one dessertspoonful before meals.

In the neurasthenic type with hypersecretion:

Subgallate of bismuth	5 grains.
Salol	3 grains.
Extract of nux vomica	⅛ grain.

Make in 1 capsule and take one-half to one hour after eating.

Strontium bromid may be used to advantage in the latter cases; sodium and strontium salicylate when the muscle or nerve pains are marked.—*Philadelphia Polyclinic*, April 11, 1896.

MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By A. W. HOISHOLT, M.D., Assistant Physician, State Asylum for Insane, Stockton. Cal.

The Epileptic Origin of Ambulatory Automatism.—DR. DEZWARTE says the name of ambulatory automatism has been given to the manifestation of certain morbid impulses occurring in neuroses as epilepsy, hysteria, and spontaneous or provoked somnambulism, or following cerebral disturbance due to traumatism. This automatism may be an epileptic equivalent, characterized by the unconscious accomplishment of the acts of ordinary life, more or less complicated with impulses to movement and travel, or it may occur after the convulsion as a part of the epileptic delirium. The same patient may be subject to the two forms at different periods. In the hysterical form, also, the impulse to movement may precede, follow, or entirely replace the convulsions. This variety of ambulatory automatism is, according to Charcot, related to the spontaneous somnambulism seen in hysterical patients, and is merely the period of "attitudes passionelles" prolonged beyond the ordinary duration. The hysterical patients are not always unconscious during the entire attack, and may be subject to imperative conceptions, which force them to accomplish certain things at all costs. The third class includes the cases of trumatic amnesia with automatism and is related to the epileptic form. Charcot mentions the case of a midwife, who, after a fall on the head, performed a delivery while unconscious of her actions during the whole time. These cases may occur some time after a fall on the head which has caused an irritation of the cerebral cortex, capable of producing attacks equal to epileptic equivalents. After attempting to show that cases considered hysterical ambulatory automatism are in reality epileptic, Dr. Dezwarte reports 3 cases in detail. The diagnosis of hysteria, which had been made in the first case, was based upon the following symptoms: The presence of certain stigmata, attacks of vagabondage related to spontaneous somnambulism, the prodromes of which, comparable to those in attacks of sleep, occur in a state of consciousness different from the normal; during the period of wakefulness there is a loss of memory of certain actions performed during the attack, which can be restored in the hypnotic state. Dr. Dezwarte, however, believed that the patient was an epileptic, relying on the history of a fall upon the head, since which time attacks of migraine had been frequent. He also called attention to the fact that the patient masturbated frequently, as most epileptics do; that he had total amnesia for the entire attack of automatism; that the mental depression, which preceded the attack in this case, is not uncommon in epilepsy, and may last several days. The patient also manifested an indifference to fatigue, exposure, or discomfort during the attacks. The wife of the patient had observed a certain absence of mind at times (absentiæ epilepticæ). Dr. Dezwarte's diagnosis was afterward verified by the development of true epileptic convulsions. The second case was in many respects similar to the first. The third case was an interesting picture of the strange impulses to vagabondage.—*Progrès Médical—International Medical Magazine.*

FORMULÆ.

By H. E. SANDERSON, Ph.B., M.D., Assistant Physician State Asylum for Insane, Stockton, Cal.

Liniment for Flatulent Colic:

Compound soap liniment	2½ ounces
Compound camphor liniment	2½ ounces
Oil of turpentine	2 ounces
Castile soap	2 drachms
Oil of cajuput	1 drachm
Oil of lemon	1 drachm

—*Bulletin of Pharmacy.*

Cold in the Head.—The following is a good prescription:

Aromatic spirits of ammonia.
Spirits of nitrous ether.

Of each 15 drops every two hours for 24 hours.—*Medical and Surgical Reporter.*

Another is: Fluid ext. gelsemium, 1 drop every hour.—*Medical Summary.*

Chronic Diarrhea and Dysentery:

Cupri sulphat.
Morphin. sulphat. . . . āā gr. i
Quinin. sulphat. . . . . gr. xxiv—M.
et. in pil. No. 12.

S.—One three times a day.—*Medical Record.*

Amenorrhea:

Ext. nux vomica . . . . . gm.	1.50
Arseniate of iron	75.00
Dry sulph. of magnesia . .	12.00

Divide into 100 pills, and take one three times daily. — *Medical Fortnightly.*

Erysipelas:

Ichthyol.
Glycerine—equal parts.
—*Philadelphia Polyclinic.*

Ringworm Lotion:

Aromatic sulphuric acid.
Spirits nitrous ether.
Creasote—of each equal parts.

S.—Apply once a day.
—*Bulletin of Pharmacy.*

Sneezing.—For obstinate and prolonged sneezing inject spirits of camphor well back into the nostrils.—*Medical Record.*

PUBLIC HEALTH.

By W. R. Cluness, M.A., M.D., San Francisco, Cal.

Mortality for August, 1896.—The deaths registered in 50 town districts of the State, during the month of August, in a population of 749,130, correspond to an annual rate of 13.68 a thousand, the total mortality having been 855. 79 deaths were due to zymotic diseases, giving an annual rate of 1.26 a thousand. Of these 6 were due to diphtheria, 28 to cholera infantum, 18 to typhoid fever, 5 to diarrhea and dysentery, 9 to cerebro-spinal fever, 4 to whooping cough, 6 to croup, 3 to intermittent and remittent fevers, 0 to scarlet fever, 0 to measles, and 0 to small-pox. 190 deaths resulted from diseases of the respiratory organs, giving an annual rate of 3.03 a thousand. Of these, 129 were due to consumption, 42 to pneumonia, 14 to bronchitis, and 5 to pulmonary congestion; the rate being, for consumption and pneumonia, 2.06 and 0.67, respectively. 95 deaths resulted from diseases of the heart, 2 from alcoholism, 2 from erysipelas, 38 from cancer, and 426 from causes not given. The average annual death rate from all causes occurring in the ten largest cities and towns in the State, and representing a population of 618,000, was 13.92. The highest rate for the month occurring in cities having a population of 10,000 or more inhabitants, was reported from Fresno, the lowest from Alameda.

METEOROLOGY.

Summary for August, 1896—*Temperature.*—The normal temperature of the State for August is 73.7°; the average for August, 1896, was 73.8°, a departure from the normal of +0.1°. The highest monthly mean was 99.6°, at Volcano Springs; the lowest, 55°, at Bodie. The maximum temperature was 125°, at Volcano Springs, on the 13th. The minimum, 26°, at Bodie, on the 3d. The absolute range for the State was 99°. The greatest local monthly range was 63°, at Barstow; the least, 15°, at Point Lobos.

Rainfall.—The normal precipitation for the State for August is 0.03 of an inch; the average for August, 1896, was 0.32 of an inch, a departure from the normal of +0.29 of an inch. The greatest monthly precipitation was 1.83 inches, at Bodie; the least, nothing, at numerous places throughout the State.

Wind.—The prevailing direction of wind was W.N.W.

Unusual Features.—The unusual meteorological feature of the month was the numerous cloudbursts and severe thunder and lightning displays in various parts of the State.—James A. Barwick, Director California Weather Service.

California—Tabular Statement for August, 1896.

STATIONS.	TEMPERATURE.						RAINFALL.		Mean Relative Humidity	WEATHER.			WIND.	FURNISHED BY—
	Mean	Highest	Lowest	Mean Highest	Mean Lowest	Mean Daily Range	No of Days Rain Fell	Total Rainfall		No. of Clear Days	No. of Fair Days	No. of Cloudy Days	Prevailing Direction.	
Auburn .... Cal.	72.7	95	58	----	----	----	----	0.25	----	----	----	----	S.W.	Southern Pacific Company.
Berkeley......... “	64.0	78	54	72	57	15	2	0 90	86	8	16	7	S.	Obs. University of California.
Colfax........... “	73.4	95	50	----	----	----	----	0.10	----	----	----	----	N.E.	Southern Pacific Company.
Coronado........ “	----	----	----	----	----	----	----	----	----	----	----	----	----	Hotel del Coronado.
Eureka.......... “	60.0	72	51	65	55	10	5	0.70	88	1	22	8	N.W.	Weather Bureau Dept. Agr.
Fresno.......... “	80.0	102	57	96	64	32	1	0.15	40	23	6	2	N.W.	“ “ “
Keeler.......... “	85.4	110	68	----	----	----	----	1.42	----	----	----	----	S.	“ “ “
Los Angeles.... “	71.0	91	54	82	60	22	1	0.01	77	8	21	2	W.	“ “ “
Monterey....... “	63.0	80	52	----	----	----	----	0.50	----	----	----	----	W.	Southern Pacific Company.
Napa........... “	69 0	94	47	83	55	28	2	0.46	74	9	18	4	S.S.W.	Station Napa Insane Asylum.
Oakland......... “	63.0	80	53	71	55	16	3	0.68	84	14	12	5	W.	Chabot Observatory.
Paso Robles.... “	76.0	100	56	90	61	29	2	1.19	----	12	17	2	S.W.	Agr. Experimental Station.
Red Bluff....... “	79.0	100	59	93	65	28	1	0.54	37	20	10	1	S.E.	Weather Bureau Dept. Agr.
Sacramento. ... “	72.0	95	54	87	58	29	1	0.20	62	19	10	2	S.W.	“ “ “
San Bernardino “	75.0	100	50	94	56	38	1	0.17	----	28	2	1	W.	A. K. Johnson, M. D
San Diego....... “	69.0	88	59	75	64	11	2	0.13	79	25	5	1	N.W.	Weather Bureau Dept. Agr.
San Francisco.. “	60.0	72	52	65	54	11	3	0.09	87	13	12	6	W.	“ “ “
Santa Barbara.. “	68.0	86	56	75	60	15	0	0.00	74	21	6	4	W.	Hugh D. Vail.
Santa Cruz...... “	65 0	91	45	79	50	29	1	0.73	----	19	7	5	W.	W. R. Springer.
Yuma.......... A. T.	90.0	113	71	104	76	28	7	0.32	51	23	6	2	S.W.	Weather Bureau Dept. Agr.

Blank (----) indicates data missing.

Occidental Medical Times.

COMMUNICATIONS are invited from all parts of the world. When necessary to elucidate the text, illustrations will be furnished without cost to the author.

SACRAMENTO: OCTOBER, 1896.

THE LANE MEDICAL LECTURES.

At the commencement exercises of Cooper Medical College, held December 5, 1895, DR. L. C. LANE formally announced that he "had founded and made financial provision for the maintenance of a course of lectures, to be known as 'The Lane Course of Medical Lectures,' to be delivered annually at Cooper Medical College." The person selected each year to deliver the course was to be "a man of prominent distinction within the sphere of medical art and science, who may be chosen from any part of the world." The lectures were "not to be less than ten in number, were to be delivered in the English tongue, and to remain the property of the author." At that time it was also announced that DR. WILLIAM MACEWEN, of the University of Glasgow, would deliver the first course. The course was delivered during the week beginning Monday, September 14th, and elsewhere in this issue we have noted in detail the more prominent features of the inauguration. In point of attendance, in the interest taken in the lectures by the profession of the State, and in the material presented by the lecturer, the first course may be pronounced an unqualified success. That it was not as complete as the founder had anticipated was due only to a misunderstanding, such as frequently attends the inauguration of any enterprise.

The selection of PROF. MACEWEN was a particularly happy one. As a surgeon and operator, and as an original investigator and thinker, he stands in the first rank of the medical profession in Great Britain. His work in connection with operative surgery has long been original, as is shown by the number of procedures that he has devised, several of which bear his name. It is, however, in connection with cerebral surgery that he is most widely known. In this field, both as an investigator and as an operator, he occupies a leading position, and the good judgment of the founder of the course was well shown in "broadly hinting" that the most fitting subject would be "Surgery of the Brain." As lecturer and operator, and as a representative of the best type in our profession—an unassuming gentleman, PROF. MACEWEN has made many friends on the shores of the Pacific. As a speaker, his delivery is easy, his language clear and concise, and his evident mastery of the subject in hand enables him to readily hold the attention of his audience. When speaking on other topics, as in his lecture on "Antisepsis," and in his demonstration of methods adapted for "The Radical Cure of Hernia," the same easy method of delivery was just as apparent. If such results may be expected in future years the Lane Course of Medical Lectures will have a marked educational effect not only upon the students of the college, but upon the profession at large. Their influence cannot but tend to broaden medical thought and medical practice. As PROF. MACEWEN himself said: "The idea is an excellent one—not, you understand, because I am here; I believe such a course will have great effect in broadening medical thought, and it would be a good thing if such a plan could be carried out on the other side of the water." Less than a year hence, or some time in September, 1897, the second annual course will be delivered by MR. CHRISTOPHER HEATH, of London, who as a representative of English surgery needs no introduction. The subjects of his lectures are already under discussion, and we hope to make a preliminary announcement of their scope early in the coming year.

There are some details in connection with this annual event, which experience seems to show, might be arranged so as to give more general satisfaction. It is now apparent that there are many outside the students of Cooper Medical College who desire to avail themselves of the rare opportunity that will be presented, each year, of meeting acknowledged leaders of our profession. To accomplish the best results it is first essential that a full programme shall be published in advance, and shall not be departed from except under stress of circumstances. On the present occasion men would have come long distances to hear some particular portion of the course, if a positive assurance could have been given that a special day and hour had been set apart therefor. In one instance a change in programme, over night, disappointed visitors who had come with the assurance that they would hear the desired lecture. Another point which seems worthy of consideration, is the change of the lecture hour. Those decided upon for the present course were 11 A. M. and

2 P. M. These hours made it extremely difficult, if not impossible, for men in active practice in San Francisco, to attend regularly, while those within a radius of one hundred miles of San Francisco were compelled to lose one day or portions of two days, in order to be present. We would suggest that the lectures proper, be delivered at 8 o'clock in the evening. This hour is not an unusual one for similar events elsewhere. It will enable a far larger number of the local profession to be present, while men within a reasonable distance of San Francisco can transact their business, attend a lecture, and be back at their posts the following day. Operations and demonstrations on matters accessory to the regular course could be held at an early morning hour, as 9 or 10 o'clock. We believe that this arrangement will be productive of advantage to the greatest number.

Under the conditions of the founder, each course of lectures will remain the property of the author, and no attempt has been made to infringe on them upon this occasion. We have, however, much pleasure in announcing that very full abstracts of the lectures on "Cerebral Surgery" will appear in our next issue, and that the remaining lectures on "Antisepsis" and "The Radical Cure of Hernia" will appear in full at a later date.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF SAN FRANCISCO.

On the 18th day of June, 1896, articles of incorporation of the College of Physicians and Surgeons of San Francisco were filed with the Secretary of State. The institution, as its name implies, will be located in San Francisco. Its purposes are: "The didactic and clinical teaching of medicine, surgery, and dentistry; the establishment and maintenance of a college hospital and clinic for that purpose; the granting of the degrees of Doctor of Medicine and Surgery, Doctor of Dental Surgery, and Fellow of the College of Physicians and Surgeons of San Francisco." The following are the names of the Trustees, each of whom have subscribed the sum of $25: SILAS MERCER MOUSER, San Francisco; WINSLOW ANDERSON, San Francisco; JOSEPH REGIST LAINÉ, Sacramento; SAMUEL OTWAY LEWIS POTTER, San Francisco; WILLIAM FREEMAN SOUTHARD, San Francisco. The term of existence of the corporation is to be fifty years. The Trustees have organized by electing the following officers: S.

M. **Mouser**, President; J. R **Lainé**, Vice-President; S. O. L. **Potter**, Secretary; W. F. **Southard**, Treasurer.

The faculty as at present announced is as follows: J. R. **Lain** Professor of the Principles and Practice of Surgery and Clinical Surgery, and President of the Faculty. **Winslow Anderson**, Professor of Gynecology and Acting Professor of Chemistry and Toxicology, and Dean of the Faculty. S. O. L. **Potter**, Professor of the Principles and Practice of Medicine and Clinical Medicine. S. M. **Mouser**, Professor of Pathology, Histology and Bacteriology. W. F. **Southard**, Professor of Ophthalmology, Otology, Rhinology and Laryngology. E. G. **Frisbie**, Professor of Orthopedic Surgery. F. H. **Payné**, Professor of Physiology and Hygiene. A. E. **Osborne**, Professor of Diseases of the Mind and Nervous System. A. E. **Regensburger**, Professor of Dermatology. W. S. **Whitwell**, Clinical Professor of Diseases of the Mind and Nervous System. E. E. **Kelly**, Professor of General, Descriptive and Surgical Anatomy. D. A. **Hodghead**, Professor of Obstetrics and Diseases of Children, and Acting Professor of Materia Medica, Pharmacology and Therapeutics. F. **Donaldson**, Professor of Physiology and Histology. **Bartholomew Noyes**, Professor of Medical Jurisprudence.

The regular course of study includes four annual winter terms of six months' actual work and an annual summer course of three months' duration. The requirements for admission seem to be rather elastic, as expressed by the prospectus: "No absolute rules are contemplated in regard to the admission of students to advanced standing, lest injustice be thereby done in any deserving instance, but each case will be decided upon its own merits. In general, applications for advanced standing will be made in writing upon a form furnished by the college; will be examined by a standing committee, and will be acted upon by the faculty after due investigation and examination."

The college building is located on the corner of Howard street and Howard Court, between Fourth and Fifth streets. It has not as yet been fitted up for the purposes of the new school, and while no doubt sufficient for all purposes hardly justifies the florid language of the prospectus, which is calculated to deceive. The location of the college ought to insure, as has been asserted, ample clinical material. The dental faculty has not yet been organized.

There is now no lack of facilities for medical education on this coast. In Portland, Oregon, there are two medical colleges in active operation; in San Francisco there are the three departments of the University—Medical, Dental and Pharmaceutical, Cooper Medical College, and the Polyclinic for post-graduate instruction, while in Los Angeles we have the Medical Department of the University and an independent Polyclinic. The new college, in addition to furnishing instruction in medicine, will also include dentistry as a separate course, and we now hear that there are prospects of a new Polyclinic for San Francisco, in addition to the one already in existence.

NOTES.

San Joaquin Valley Medical Society.

The San Joaquin Valley Medical Society will meet at Fresno on October 27, the date having been changed from October 13, owing to some local misunderstanding. The following papers have, so far, been promised: "Alcohol, its Uses in Medicine," by W. T. Maupin, Fresno. "Eye Bandages," by C. J. Miner, Fresno. "Pathology and Treatment of Chronic Indolent Ulcers," by P. N. Russell, Fresno. "Malaria," by J. A. Moore, Hanford. "The Treatment of Malaria," by D. H. Trowbridge, Fowler. "Therapeutics of Diseases of Children," by W. H. Miller, Hanford.

Transportation Arrangements for the Pan-American Medical Congress.

Dr. H. L. E. Johnson, 1400 L street, N. W., Washington, D. C., has been elected Chairman of the Special Committee on Transportation. All communications relative to rates, reservation in the special trains, etc., should be addressed to him. A rate of one fare for the round trip has been secured between St. Louis, New Orleans, and other trans-Mississippi points and the City of Mexico. It is confidently expected that this rate will be extended over the entire territory of the United States. Arrangements are in progress for a splendidly equipped special train of sleeping and observation cars, with first-class dining-car service. Dr. Johnson will presently be in position to announce a rate, which will include railroad fare, sleeping and dining car service both ways and in the City of Mexico, and covering the expense of various side trips to the most historic points in the Republic.

California Northern District Medical Society.

The sixth annual meeting of the California Northern District Medical Society will be held in Red Men's Hall, Second street, Marysville, on Tuesday, October 13. The following papers have been announced: Annual address by the President, A. W. Hoisholt, Stockton; "Commitment of Persons Alleged to be Insane." "Malaria," by T. P. Peery, Yuba City; discussion opened by H. D. Lawhead, Stockton. "Backward Displacement of the Uterus," by W. A. Briggs, Sacramento; discussion opened by David Powell, Marysville. "A Case of Compound Comminuted Cranial Fracture—Operation, Recovery," by A. P. Tartar, Tehama; discussion opened by A. T. Hudson, Stockton. "Aseptolin," by S. E. Latta, Stockton; discussion opened by C. E. Stone, Marysville. "Local Anesthesia," by John Fife, Red Bluff; discussion opened by J. H. Parkinson, Sacramento. "Ununited Fracture of the Tibia," by S. J. S. Rogers, Marysville; discussion opened by T. W. Huntington, Sacramento. There will be a morning and afternoon session only. In the evening the visitors will be entertained by the Medical Society of Yuba and Sutter Counties at the new Western Hotel. Any physician who is a member of his local Society, where one exists, is eligible for membership. The initiation fee is $2; the annual dues being the same amount. The railroad facilities for reaching Marysville are excellent, and there is every promise of a good attendance.

A Second Antitoxin Collective Investigation by the American Pediatric Society.

Encouraged by the success of its recent antitoxin collective investigation, a report of which appeared in our issue of August, the American Pediatric Society now asks the coöperation of the profession in a further collective investigation. Laryngeal diphtheria is believed to furnish a crucial test for antitoxin; the present aim is to ascertain: (1) What percentage of cases of laryngeal diphtheria recover without operation under antitoxin treatment. (2) What percentage of operated cases recover. The Society asks for records of cases of diphtheria involving the larynx, whether operated upon or not, occurring in private practice in the United States and Canada treated with antitoxin. It is expected that cases occurring this year will be treated with reliable preparations of serum, will be treated early, and will be given efficient doses. The second report is designed to be a study of cases occurring between the closing of the first report, May 1, 1896, and the closing of the present collective investigation, April 1, 1897. In order to secure data which shall make the tables complete, circulars containing blanks for ten cases have been printed and are now ready for distribution. It is desired that physicians shall fill out the blanks, as cases occur, not trusting to memory, and that they shall urge their friends having similar cases to do the same. Several groups of cases in the first investigation arrived too late and were lost to the report. It is desired that said blank as soon as filled be returned to the committee. The collection of cases must close March 31, 1897. For the necessary blanks, and for further information, address the Chairman of the committee, W. P. Northrup, 57 East Seventy-ninth street, New York.

The Woodbridge Treatment of Typhoid Fever—A Correction.

Messrs. Parke, Davis & Co. have called our attention to a statement appearing in our issue of March, 1896, which they believe is calculated to do them an injustice. The statement is contained in a paper by Dr. W. N. Sherman, of Merced, on "The Woodbridge Treatment of Typhoid Fever," and can be found on page 137. It is as follows: "Other preparations are on the market, labelled 'for the abortive treatment of typhoid fever,' and I should advise you to avoid prescribing such preparations. I regard it as dangerous to the best interests of the profession, as it is a temptation to druggists and laymen to prescribe for others." From a cursory reading it appears that as Parke, Davis & Co. have marketed a preparation which, in its various styles, is labelled "Dr. Woodbridge's Abortive Treatment of Typhoid Fever," and on another portion of the package "Abortive Treatment of Typhoid Fever," it is presumable that the language used by the author of the paper referred to the products of this house. Without reference to the author, we are of the opinion that the criticism in question was directed not against the product of the manufacturers which is above question, but rather against their method of labelling it. The facts are, that Dr. Woodbridge, of Youngstown, Ohio, several years ago, handed his formulæ to Parke, Davis & Co. in order that physicians generally might be enabled to test the merits of the treatment without risk of failure through errors on the part of druggists compounding the formulæ, as already published, or from the inferior quality of the ingredients which might be found in local pharmacies. The style of the label is that suggested by Dr. Woodbridge, as will be found by reference to any of his writings. In thus following his directions the manufacturers did as would naturally be expected under the circumstances. There is no patent, copyright, or trade mark in connection with this matter, and the formulæ, as published, are true. While there is no proprietorship whatever in the matter, it is only fair to say that Parke, Davis & Co. were the original manufacturers of the preparations at the selection of Dr. Woodbridge, and have since continued to enjoy his confidence. We have much pleasure in making this statement, and, in confirmation of the same, would refer any of our readers to Dr. Woodbridge, who has always seemed ready to afford information to inquirers.

Homicide at the Stockton Asylum.

On Tuesday, August 18, 1896, at about 8:30 A. M., a patient, O. C——, who was committed to the Stockton Asylum October 4, 1895, and whose mental symptoms had been those of an acute mania, was struck by another patient, C. G——, the subject of chronic mania, who had been an inmate since March 1, 1894. Both patients were confined in a violent (though not the most violent) ward of the institution. The assailant had for a year or over been employed in the ward, sweeping and polishing the floors, etc.; he had been known to fight with his fists on a few occasions, and to kick other patients, but had never made an attack on anybody with weapons. The victim had, at times, been in the habit of kicking or striking, but was not a particularly violent patient. On the morning of the fatality C. G—— was polishing the floors with what is known as a rubber—a piece of timber covered with blankets, which is used in rubbing wax into the surface of the floors. The attendant was sweeping up the dust at his room door, when he heard a noise as of a man falling to the floor—the noise coming from an alcove or bay window about fifty feet away from him. He pushed his door shut immediately, went to the bay window, when he found O. C—— lying prostrate on the floor on his right side. C. G—— walked out of the bay window down the hall in the opposite direction, continuing the polishing of the floor with the rubber, as if nothing had happened. There was no other patient around at the time, and the attendant did not hear any noise except that made by O. C—— in falling. He appeared to be unconscious at first, but afterwards opened his eyes. When seen by the physician his eyes were shut and he acted as if unconscious, which, however, had often before been his demeanor when interviewed on any occasion. He was bleeding from a small cut over the left eye; on the top of the head, about an inch to the left of the posterior extremity of the sagittal suture, there was a slight swelling. Careful examination of this part of the head, however, failed to reveal crepitus or displacement of bone, nor were there any focal symptoms to indicate a localized brain injury. Soon after it was ascertained that the stupor of the patient was not assumed, as he remained unconscious and gradually grew worse until coma resulted. He died on the following day at 2 P. M. The Coroner was notified of the occurrence and an inquest was held; the verdict of the jury being that the man came to his death by a blow dealt by the patient C. G——. A *post-mortem* examination was held, and a fracture was found to extend from the posterior superior angle of the parietal bone downwards through the squamous portion of the temporal bone into the petrous portion as far as foramen lacerum medium, the petrous portion being fractured in two or three directions. There was a layer of clotted blood under the scalp averaging one-eighth of an inch in thickness, and between the skull and dura mater, a blood clot was found, which, in its thickest part, measured nearly half an inch. These clots covered two-thirds of the cortical surface of the left hemisphere including the inferior surface of the temporal convolutions. Exudations of blood were also found in the pia under this blood clot, and in the pia of the right hemisphere at a point below the inferior half of the right fissure of Sylvius.

SPECIAL ARTICLES.

THE LANE MEDICAL LECTURES.

The first course of the "Lane Medical Lectures," that will hereafter be an annual event, was inaugurated at Cooper Medical College on Monday, September 14, 1896, by PROFESSOR WILLIAM MACEWEN, of the University of Glasgow. According to the terms of the foundation, and as had been originally announced, the course should have consisted of ten lectures, but in making arrangements for the initial series there was, as might have been expected, some misunderstanding. On his arrival it was found that PROF. MACEWEN had only provided for five lectures, but he at once offered to make up the deficiency in any way. It was finally arranged that the five lectures on cerebral surgery should be delivered each morning and that during the afternoon other lectures on different topics would also be given. In accordance with this arrangement, PROF. MACEWEN delivered a lecture on "Antisepsis" and one on "Radical Cure of Hernia," and, in lieu of the remaining lectures, on one afternoon he performed "Macewen's Operation" for genu valgum, and on the last day trephined the mastoid, at the same time outlining the various steps for the relief of cerebral and cerebellar abscess in connection with mastoid suppuration. The operations were performed in the clinical amphitheater of the College which, as will be noticed elsewhere, was referred to by the distinguished visitor as being admirably suited for its purpose.

While the inauguration of this course of lectures is a recent event, the idea of their institution, on the part of the founder, has long been a pet scheme. It had been carefully worked out several years ago, but at the time there seemed to be many things that the increasing demands on the College rendered more urgent. Finally, one by one the more pressing needs of the hour were satisfied and the way prepared for some of the plans that would make the educational facilities at Cooper broader and more comprehensive. In this connection, the following from the pen of DR. LANE will best convey his intentions and purposes:

"The reasons which suggested the foundation of the 'Lane Course of Lectures,' are the following: Some years ago I went abroad and spent over two years in studying the medical institutions of Europe; and more recently I spent a short time in visiting some of the leading medical schools of our own country. I observed that almost every school had some special excellence, which was peculiar to itself, and which depended on one or two professors connected with it. In fact, almost every celebrated school owes its reputation to the individuality of one man who has reached distinction through original work in some section of medicine or surgery; and the medical student who visits such an institution does so for the purpose of seeing this man and hearing his living words. But a small number of the students of Cooper Medical College will ever be so situated that they can visit the great lights in our profession, and certainly they cannot do so during their pupilage. The character of students is molded and modeled after the character of those who are their instructors, and whom they regard their superiors. Whatever seed is planted in the student's mind will germinate there and give form to his future life. As the original is, so will the derivatives be modeled. As ribaldry, vulgarity, boastfulness, and shallowness are easily propagated in the fertile seed-plot of the student's mind, so their opposites—decency, nobility, modesty, and breadth and depth of knowledge may, by the teacher, be planted in the youthful heart and mind, and have perpetual growth there. Hence, one reason for the foundation of this course of lectures is to mold into the best forms of excellence the students who may visit Cooper College, by bringing them annually into contact with a master mind. Besides getting knowledge thus from its primitive source, the students from annual contact with a great mind will thence derive a perennial inspiration, which will animate and sustain them in their toilsome hours. Another reason for establishing this course is the influence which it will have on the Faculty of the school; they, too, in common with the students, will be stimulated to renewed effort in their respective spheres; and thus the teachers will be prevented from falling into that listless perfunctory and routine method of teaching which is so dwarfing in its influence on the student. "The work which has recently been done by PROFESSOR MACEWEN fully attest the wisdom of his selection for the inauguration of the 'Lane Course of Medical Lectures.' These lectures were masterpieces; in language they were clear, concise, logical, and richly laden with the mature fruit of original research. His statements of facts was given with a candor, modesty, and absence of self-parade that won the sincerest respect of all who listened to PROF. MACEWEN. "When Troy should fall it was agreed that the victory should be announced at home through sentinel lights successively lifted on mountain, crag, cliff, and vale between Troy and Greece. So the founder of this course indulges the hope that these lectures in future, appearing successively in the coming years, will be beacon lights on which with delight the alumni and students of Cooper Medical College will repose their eyes."

The lectures were delivered in the spacious auditorium attached to the College. The attendance was always large, and while mainly composed of the students for whom the course was primarily established, there were also a number of medical men present. Amongst these, many prominent in the local profession were noticeable, and on the different days physicians practising within a radius of one hundred miles from San Francisco, had thought it worth their while to attend. Shortly after 11 A. M., on Monday, September 14, PROF. MACEWEN was escorted to the platform by the Faculty, and was then formally introduced to his audience by DR. L. C. LANE, who spoke as follows:

"Students of Cooper College, Alumni of the College, and members of the medical profession: As has been publicly announced, a course of lectures founded by me some years ago, will now be inaugurated by PROFESSOR WILLIAM MACEWEN, who has been chosen for that task. PROFESSOR MACEWEN has attained a great deal of distinction along one line of surgery, namely, cerebral surgery, or surgery of the brain, and in consequence his lectures will be, in the main, devoted to that subject. Every day this week, at 11 o'clock, he will lecture upon that subject. He has consented also to diverge somewhat from that matter, and in the afternoon we will also have some lectures, and perhaps a surgical operation or two by him. The subjects which will be given in the afternoon are: The methods of treating wounds antiseptically; that is, embracing the subject of what we call antiseptic surgery. The second subject will be the treatment of the enlarged prostate gland. I may remark that in that chapter or section of surgery, great advances have been made in the last few years, entirely new methods of treatment have been devised, and PROFESSOR MACEWEN has kindly consented to tell us something about that matter. He has also given a great deal of attention, and is mentioned among those who have done much work for the radical cure of hernia, and one of the methods known for that purpose and which you see in your text books, is that of PROFESSOR MACEWEN. He will give one hour on one afternoon for the radical cure of hernia. Another hour will be given to the subject of surgery of the lungs, which he has suggested might be a proper one for a lecture. These lectures in the afternoon, will be given here from 2 to 3 o'clock. I now, with a great deal of pleasure, introduce to you PROFESSOR WILLIAM MACEWEN.

In preparation for the lectures a number of diagrams in colors descriptive of cases that had been operated upon by the lecturer were placed upon the walls at the back of the platform and were used for illustrating points in localization and treatment. A very large number of beautiful sections were also shown by the sterіopticon, and duplicates of each section shown were arranged in regular order at the front of the platform, so that they could be referred to after each lecture. These sections were, in the main, prepared by freezing the subject. In this way the exact anatomical lines and relations were preserved. Structures were here demonstrated in outline and position that never appear in the textbooks. This was especially well shown in the form of the intradural spaces both normal and morbid, a most accurate conception of the effects of pathological processes being readily conveyed.

The first lecture was in a sense preparatory to those that followed and was mainly devoted to anatomical details, with allusion to function and localization when bearing directly on the demonstration. One of the first points brought out by the sections shown was the roundness of outline and greater fulness in all directions of the brain during life as opposed to the results found *post-mortem*. The bearing of this on operative procedure was that brain tissue was encountered rather closer to the periphery than the brain of the dissecting room would convey. The importance of the subdural space when its great extent was considered in relation to acute infectious processes was beautifully shown by the frozen sections.

The second lecture dealt with localization in relation to the special centers that have been definitely isolated. Here the colored diagrams of cases that had been operated upon by the speaker were most valuable. Each case of this character might be regarded as an original experiment. The success of the experiment being shown by the relief of the symptoms following the operation, or by the *post-mortem* examination, with its fuller details. Steriopticon views were also used in this lecture to show sections of tumors *in situ*. A point brought out most prominently here was the effect of operative procedure in cases of acute hydrocephalus. The frozen sections showing plainly that the withdrawal of the fluid must inevitably be followed by collapse of the attenuated brain matter that, in some cases, formed merely a layer between the fluid and the dura. The clinical details of the cases reported in illustration were admirably rendered, giving this portion of the lectures all the interest of a well told narrative, from which nothing of importance had been omitted. The difficulties in diagnosis were well brought out, and the trouble experienced in unravelling the complex symptoms produced by interdependence of function, both psychical and physical, of adjacent areas, was shown.

In his third lecture **Prof. Macewen** diverged somewhat from the original programme to speak of the mode of detection of cerebral and cerebellar tumors and their treatment. The symptoms were first reviewed in detail, the local and the general being pointed out, and their dependence next considered. Some that were common to other conditions should always be borne in mind for elimination. The fact never to be forgotten in diagnosis was the remote effect that distension of the brain by a growing intracerebral mass might exert at remote points. The lecturer asserted that it was possible by percussion to determine the presence of any considerable accumulation of fluid in the ventricles, and the method of eliciting this sign was demonstrated. Certain symptoms as those of the eye and of the circulatory system were constant, but others were very variable. The methods of operating for the relief of these conditions were briefly taken up, and the means of dealing with complications, such as hemorrhage, were pointed out.

The fourth lecture which would properly have been the third in the series took up the subject of the acute infectious processes. Here the onset of symptoms and of the gravest results was comparatively rapid, demanding prompt relief. There were two errors that had been very generally held by the profession. The first was that an abscess of the brain was only part of a general pyemic infection, and that, therefore, its treatment must be regarded as hopeless in the extreme. The other was that the lesion was so infrequent in its occurrence and so erratic in its location that skill in dealing with it, and the practicability of its complete evacuation, were to be rarely attained. He showed, from his own personal experience, that abscess of the brain could not be regarded as such an infrequent occurrence, and that it was certain that many cases were never diagnosed during life, while a fair proportion were not recognized even by *post-mortem* examination. The next point as to the location of this class of lesion was most practical. The lecturer demonstrated conclusively that the vast majority of these cases originated from chronic suppurative processes in the middle ear. This, when accepted, not only opened the way to a ready diagnosis, but also gave a step by step mechanical process by which the lesion could be approached and successsully attacked. Meddlesome treatment in middle ear disease, of a chronic character, and its fatal result, was pointed out, and the necessity of the most radical measures when the danger line was approached was clearly shown.

The fifth lecture was devoted to a resume of the symptoms and indications for operation in cases of abscess and sinus thrombosis. The different methods of operating were also taken up in a more specific manner than on former occasions. One of the first points made by the speaker was that the temperature record was no indication whatever of the mischief that might be going on inside the brain. With sinus thrombosis, on the contrary, the temperature was a very reliable guide. The same rule applied to rigors which were few or absent with abscess, but always present and often frequent in thrombosis. The varying symptoms of the two conditions already mentioned and of meningitis were very fully discussed and contrasted before the lecturer proceeded to the method of operating that he deemed most advisable. The first point in these cases was to reach the mastoid antrum. This was not only a guide in all future steps if further interference were contemplated, but its condition directly implied that of the adjacent parts and the well recognized indications at that point could be availed of by the operator. To open the mastoid he discards the hammer and chisel, which he believes are unsafe, using only a small hand gouge and a burr with the ordinary dental engine to supply the motive power. That these means, though new to operators in this country who follow, mainly, the German methods, were all sufficient, the lecturer demonstrated later in the day, when he opened and cleaned out a mastoid antrum in the most approved manner.

At the conclusion of the lecture on Friday, DR. L. C. LANE said: This is the final lecture of the course. In commendation of them many words might be said, but they speak and have spoken for themselves. I will announce that in September, one year hence, we have secured a worthy successor to PROFESSOR MACEWEN, namely, MR. CHRISTOPHER HEATH, late President of the Royal College of Surgeons and Professor of Surgery in one of the leading medical schools of England, University Medical College. I am satisfied that no abler or more worthy man could have been chosen than MR. HEATH. Through both his scalpel and his pen he has long since been accredited an enduring position in surgery, so that the authorities of Cooper Medical College are gratified that in September, 1897, they will be able to present to their students so eminent a teacher. Addressing the lecturer, DR. LANE then said: PROFESSOR MACEWEN, the several classes of Cooper Medical College desire to express their appreciation of your course. The Presidents of two of these classes are here and will present their little address to you.

MR. W. T. BARR, President of the Senior Class, then spoke as follows: PROFESSOR MACEWEN, it is with pleasure that I, as a representative of the students of Cooper Medical College, take this opportunity of expressing to you our thanks and appreciation for the course of lectures that has been delivered to us. Situated as we are, on the western coast of the United States, bounded on one side by a great plain and on the other by the Pacific ocean, we are in a measure isolated from the great educational centers of the world. We are filled with gratitude to you for coming all the way from Scotland to deliver a course of lectures to us, and we wish you to know that we appreciate the great privilege which we have enjoyed in coming face to face with one who has done so much for the art of surgery, and whom we have known by his works and writings and have revered from afar. We wish also to express our thanks to DR. LANE and to MRS. LANE for the foundation of the Lane Course of Medical Lectures, by which we are brought annually into a sort of personal relation with the great educational centers of the world. To say that we thank you is an inadequate expression for the gratitude we feel, and this feeling of gratitude can only be shown by the better work that will be done by the students of Cooper Medical College, and by the advancement of the medical profession of the Pacific coast. While we are proud of being present at the inauguration of this course of lec-

tures, we congratulate the students who are to follow us that they will hear a similar course of lectures each year at Cooper Medical College.

PROFESSOR MACEWEN: Sir, I have to thank you for the goodness with which you have expressed on behalf of the students their appreciation of my efforts, which I find, alas, all too imperfect. You have mentioned, however, some points that I scarcely agree with. It is quite true that you are on the borders of the Pacific, and you have a plain on the other side, but I do not think you are in any way cut off from the rest of the world. We have, now-a-days, the advantage of having a language which is easily understood by a very great section of this continent, and whatever is written in it, if it be worthy, is sure to be disseminated broadcast. And, therefore, every medical student who even writes in seclusion wherever it may be, all over the world, if he produces anything that is good and puts it into a medical journal, it will be sure to receive attention. Therefore, sir, I do not think that there is such a thing now as an isolated place. I have been trying to see such all round here, and I think you will find that everywhere, wherever at least the English language is spoken, you are not isolated; you are really "in the swim."

There is another point: It is that you do not require to be in a very old university to enable you to work. Every student, wherever he is, if he be in a new university, or if he be outside of a university, can work. A new university has a certain stimulation for new students from the fact that one is not overburdened with distinguished predecessors, and, therefore, one can manage a little more easily, perhaps, to make a name for himself. Many students fancy because they are compelled to learn so many things that, therefore, there is very little remaining to be elucidated. That is an entire mistake, as one finds when he studies. I am not quite sure, sir, if we had a medical philosopher who would, like HERBERT SPENCER, divide all things into the known and the unknown, how much he would put into the former. I am sure that he would put a very great many things that we teach into the latter; and, therefore, a student will find that there is abundance of opportunity. He need never be reduced to the miserable condition which Alexander the Great found himself in, when he wept that he had no other worlds to conquer. The more you progress the more you will have the opportunity of seeing what remains to be done. One only wishes after a time that one had longer life to study the immense field which is open to all of us.

I have looked critically at your college. I have looked also at your hospital, and I do not think that any place in the civilized world would be ashamed of Cooper Medical College. I would go further than that, and say that I wish very much that I had had for the last four years an operating theatre as perfect as that new one which is in this building. I have come personally in contact with quite a number of your teachers, and I know that you have in them men who are thoroughly reliable and who will guide you in the right direction. It has been a very great pleasure to me to find that here on the "borders of the Pacific" things are as perfect as you have them. If you do not do good work it will not be for the want of opportunity of doing it. Finally, there is this point that I wish to impress upon every student in America: It is that he has advantages which we are denied in the shape of experimenting—carefully and rightly, of course—upon the lower animals. That is an immense advantage which you possess. I hope you will always keep it. Under those circumstances it is to be expected that many interesting contributions to the field of science will emanate from Cooper Medical College. It only requires a beginning. If you begin it, and move in that direction, there will be no fear that your studies will not be appreciated.

Perhaps you might allow me to say one word in conclusion, and that is in regard to the intense interest which DR. and MRS. LANE have taken in this college. They have, indeed, been fortunate in seeing that the college has reached the stage of prosperity in which we find it. I think that must be a consolation to them. I think it likely that after—and I hope it will be a long time before this occurs—that after the two persons that I have spoken of should be removed from this sphere, the people of San Francisco, and the people of California, will be able to appreciate the amount of good work which they have done. In our country we have one man who is a very eminent politician, and who is revered independently of politics, and we call him the "Grand Old Man." I have spoken to some of you who know DR. and MRS. LANE very well, and one man summed up what he had to say in this way: "Doctor, we love him." Surely that is food for the Gods! I think, sir, that no higher tribute could be given to those two persons, and I would ask you, in concluding this series, to give one cheer for the Grand Old Man and his angel helpmate—DR. and MRS. LANE.

SOCIETY PROCEEDINGS.

SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT.

Regular Meeting, Tuesday, August 18, 1896.

The President, F. B. SUTLIFF, M.D., in the Chair.

Contract Lodge Practice.—A series of resolutions adopted by the Santa Clara County Medical Society were read by the Secretary. The resolutions, which were signed by nine-tenths of the physicians of Santa Clara county, pledged the subscribers not to enter into any agreement or contract to render medical or surgical services to any association or organization at lower rates than would be charged the public for similar services. The resolutions went into effect May 22, 1896, and are to remain in force for three years. The communication was received and placed on file, and, on motion, the Secretary was directed to mail a copy of the constitution and by-laws to the Santa Clara County Medical Society, directing its attention to the fact that this provision had been adopted by the Sacramento Society a number of years ago.

New York Life Insurance Company.—The committee appointed some months ago in connection with the "Reduction in Fees of Medical Examiners by the New York Life Insurance Company and the Equitable Life Assurance Society," reported that the Equitable Life had seen its mistake and had returned to the old schedule. The New York Life, however, had not as yet reformed. The Secretary was directed to mail a copy of the Society's circular to the New York Life, and to call the company's attention to the return to the old schedule by the Equitable.

Spontaneous Subluxation of the Knee Joint.—DR. G. C. SIMMONS exhibited a young girl who had been scalded on the lower extremities when two years of age. Subsequent cicatrization had so affected the left knee that in walking it frequently slipped out of place without any warning. When patient had hopped a few steps the joint returned to place. The patient objected to wearing any permanent appliance.

Polypharmacy and Polytherapy.—DR. THOS. ROSS read a paper upon this subject. He said: Pharmacy in the past few decades has undergone a wonderful transformation. Our druggists used to be our pharmacists. Now, great manufactories of chemical, pharmaceutical and proprietary medicines are established in every large city in the civilized world, and about all the pharmacy is done by them. New remedies emanate from these chemical workshops, by the hundreds yearly; samples of many, with abundant literature explaining their properties and extolling their virtues, are deposited in each physician's office. They are well advertised in our medical journals—in fact, some medical journals that claim to be independent are in reality owned, controlled, or conducted by these big concerns. Pamphlets—some of such pretentious proportions might be designated books—reporting cases successfully treated with the particular preparation advocated and recommending them to the profession are liberally distributed. Prescriptions, composed of secret drugs, are compounded, given a name, are advertised extensively, and are used in the treatment of disease. The profession has no means of correctly ascertaining the ingredients entering into their composition. The ingredients of proprietary medicines advertised to the profession are sometimes given, but the true formulæ—the working formulæ by which they may be compounded by the druggist—are carefully concealed. The use of such remedies must prove injurious to sick humanity, because of our want of knowledge of their composition and their therapeutic properties. On account of the strong recommendation made to me by an agent of one of these firms, of the curative effect of a proprietary medicine, in the treatment of a particular disease, I was induced to try it. It, as usual with these medicines, failed to produce the happy effects stated. On the agent's next visit to Sacramento I informed him that I tried his remedy, that it had little or no effect on the disease for which he so highly recommended it. He stated that in properly selected cases it would accomplish all that he claimed. Many drugs in the form of elixirs, fluid extracts, syrups, pills, etc., become unreliable because of their deterioration from age. We cannot tell how long the fluid extracts from which our tinctures are made, have been on the shelves of the dealers, therefore we must not be disappointed if we fail to get from their use the therapeutic effects of the pure drug. Upjohn's quinine pills have a good reputation for ready solubility in the prima via—their softness—being easily compressed between the finger and thumb leads to conviction of their easy solubility. I have taken them and was surprised to notice that they passed through the whole digestive apparatus with as little change in their form as if they were made of marble. The late Dr. F. W. Hatch had his pepsin made from the fresh stomach of a calf, from which he claimed to receive better results than from the pepsin of the shops. The multiplicity of remedies tends to induce physicians to treat diseases symptomatically, without regard to their etiology and pathology—to forget to combat and endeavor to remove the cause—to forget that where possible the only rational treatment is the removal of the cause when all symptoms will disappear. A combination in one prescription of half a dozen or more different drugs intended to combat an equal number of symptoms is sometimes prescribed, the therapeutic effect of which would puzzle even Dr. H. A. Hare to explain. With few exceptions, the more simple our prescriptions are—the fewer drugs that are combined in one prescription—the more satisfactory will our treatment be to ourselves, the more benefit to our patients, and the more successful will be our efforts to combat disease. There are many new drugs, but there are few remedies of the hundreds of "new remedies" introduced in the past decade; there are probably not more than twenty in general use. When we stop to think, in the experience of centuries, how few specifics we have—only three occurring to my mind now: mercury in syphilis, quinine in malaria, and sulphur in scabies—we cannot but be impressed with the fallacy of chasing after the *ignis fatuus* of specifics in medicine. We, however, are on the chase yet. We have ceased to look for them in the vegetable and mineral kingdoms, but we think we are on a hot trail in the animal kingdom, and we enthusiastically pursue specifics in the various antitoxins, serums, and animal extracts of to-day. We all remember the excitement made in the medical world by Dr. Brown-Sequard's discovery of the "Elixir of Life." We also remember the mad pilgrimages made by physicians from all parts of the world to Berlin to witness the wonderful and miraculous virtues of Koch's lymph. A few short years—about three—have passed since then. Koch's lymph is forgotten. We now stand aside and wonder at our credulity. Jenner's lymph is to-day the only one that is positively demonstrated to be of real value. It is well said that "the therapeutic pendulum has swung first away from botany, next away from chemistry, and presently it is predicted it will swing away from bacteriology."

Dr. G. L. Simmons: In common with the author I have been overwhelmed with the number of remedies and with the literature that has been poured upon us. In connection with this subject I am further amazed at the large number of physicians who lend themselves to a work of this kind. To aid the manufacturers in a work of this character seems to me unprofessional. I cannot but think that many of them are not following the lines originally laid down by many of the fathers of medicine, in this: that their experiences having been limited, when a patient gets well of a disease after the administration of any drug or by any process, they conclude that that was what effected the cure. I think all physicians should constantly keep in mind the fact that diseases—many of them—most of them, in fact, are self-limited. No matter what we are doing they would get well; in fact, we know that a great many diseases get well in spite of wrong treatment. I have been very much struck with this question in connection with protonuclein—that is, I have read in the literature on protonuclein of a large number of cases that have been cured by it. I have tried it, and I have not, in a single case, seen any good effect from it. I sincerely hope that the profession will not do anything in the interests of or help these wholesale manufacturers, particularly in connection with things that are secret. I believe we have, all of us, used certain preparations of which we did not positively know the composition. In the early introduction of antipyrine, for instance, I used it quite extensively. I have later come to the conclusion that, while it had certain effects, I can get the same effects with those compositions that we know about, and I think it is the duty of all physicians to prefer the latter to those of a secret nature.

Dr. W. E. Briggs: Proprietary medicines are injurious to the welfare of the profession, and also to that of the patient. I confess I sometimes prescribe them myself: but it is a bad habit. Drug firms have their secret remedies, and it seems they receive support, as they succeed. They must use a great deal, as it is constantly kept by them in stock, and for medical men to help them in this way is very unprofessional. Two years ago when the American Medical Association convened in San Francisco, the syrup of figs man received the consideration of that Society. This preparation is advertised in a great many medical journals in the United States and in the public press. The encouraging of such a remedy is certainly disgraceful to the intelligence and honesty of the profession. That practice leads to a great deal of harm, as patients become aware of the fact that physicians prescribe such remedies, and they go to the druggists and get them themselves. The profession cannot do too much to aid in creating a revolution on this subject. I would be glad to see the Society do what it can in this direction.

Dr. G. A. White: We easily get into the way of prescribing these remedies because we are rather lazy. Many of them do more harm than good. Some of them I believe in, very few, perhaps; still I am quite ready to give up all of them.

Dr. H. W. Strader: I do not know whether I prescribe proprietary medicines very much. In the case of the New York Pharmacal Association's preparations, the list of drugs they put up includes some excellent things, such as liquid peptonoids. If these are proprietary remedies, I use them.

Dr. H. L. Nichols: I indorse the sentiments of Dr. Ross's paper. I have advocated these views for years, and have been looked upon as a silurian for not having always taken hold of these things as they are brought before us.

Dr. J. H. Parkinson: I think we ought to be honest in this matter; we are all doing these things, that is, we are prescribing proprietary preparations. I think, however, that a difference should be drawn between certain classes of proprietary preparations. Some are definite chemical compounds, others are combinations of established remedies. Such manufacturers as Parke, Davis & Co., Wyeth, and Warner, have placed upon the market preparations which are both elegant and effective, and which have added largely to our resources. The granular effervescent salts of Warner are a distinct addition to our materia medica. The average retail pharmacy is not capable of preparing many of the combinations that are in daily use and that are classed as proprietary preparations. Then again, "cut rate pharmacies" do not tend to inspire confidence in the prescription druggist. Regarding serum-therapy in diphtheria, the majority of the profession are at present in favor of it. As to the influence of this method in phthisis, I believe it is, as yet, questionable. I think that the point made by Dr. Simmons, in relation to new drugs, is excellent. I am in a position to realize that there is a great tendency on the part of the profession to rush in and experiment with anything new that may be offered, utterly regardless of its value.

Dr. H. D'Arcy Power: There are two subjects that have come before us to-night, namely, proprietary medicines and the use of new drugs. In regard to proprietary medicines, a clear distinction ought to be made between medicines and foods. While I consider the use of proprietary medicines detrimental to the profession, and one of the chief reasons of slovenly prescribing, the proprietary foods are, on the contrary, very often a boon. It is impossible to give directions for making peptonoid preparations that will be as useful as those that are prepared and upon the market, and so with many others of this class. As to new drugs, young physicians are too apt to try everything that comes in their way, thus losing the knowledge of the value of old and tried remedies which can only come by their constant use. Moreover, the tests so made are valueless by reason of their scattered character. New products should be tested in hospitals or public institutions where their value can be definitely ascertained, and it is then time enough for the general practitioner to introduce them if he considers it necessary. Synthetical chemistry, while it has done great things for us, and will probably do greater, has its limits as amongst the immense number of articles placed on the market, there are only a few that will permanently remain as additions to our armamentarium, such as acetanilid, the salicylates, and a few more that might be mentioned. In regard to the question of giving testimonials in favor of drugs, I would like to ask the question, to what extent have physicians here present been quoted as giving testimony in their favor that was never given. I have been quoted as having praised Platt's chlorides, whereas, as a matter of fact, I have never given any testimony in its favor or in favor of any other drug.

Dr. Florence B. Power: In speaking of new drugs it seems to me that physicians who find a new drug efficacious ought to mention it. I should like to say that I have found very much benefit from acetanilid. I have been suffering from sciatica, and if I did not have acetanilid to take, I would have been dead by this time. I have never increased the dose to more than 5 grains. I have taken it, I think, three times a day when I had my bad attacks, when feeling pretty well taking but one dose, which controlled my pain and my nerves to a great extent.

Dr. G. C. Simmons: I would like to take exception to what has been said in regard to Koch's lymph. I believe that Koch's lymph is better than its followers, such as tuberculin and antiphthisin, which are put on the market, and better than any pharmaceutical preparation for the treatment of consumption, and while some mistakes were made in the beginning regarding Koch's lymph, it stands, in my opinion, far better than anything we have in the medical line.

Dr. C. L. Browning, of Folsom: I would like to congratulate Dr. Ross upon his paper, and to emphasize what Dr. Simmons has said in regard to men who lend their names in aid of all the remedies put forth by the different firms. I think some of them are enthusiasts who think when they cure one case with any remedy they can cure all. Some like to see their names in print. I think there should be some means taken to suppress these things. We know that the great majority of these medicines do not, by any means, come up to the claims made for them. I have tried protonuclein and found nothing in it. We do, however, run across medicines which there is something in, and if, when physicians find such, they would say so in the societies, it would be a help. If there is a medicine, proprietary or patent, that will positively cure any one disease, I will use it all the time. I have only found two or three medicines that are good specifics.

Dr. Power: In regard to reporting things which we find to be efficacious, as mentioned by the last speaker, some months ago that was instituted here, and blanks were furnished with the understanding that members of this Society would report anything of value they might find in this direction, and return to me. So far I have not had a report, and I think it is about time some were coming in.

SAN FRANCISCO COUNTY MEDICAL SOCIETY.

Regular Meeting, August 11, 1896.

The President, **Wm. Fitch Cheney, M.D.**, in the Chair.

Dr. A. Liliencrantz read a paper on "Lessons Learned from Dead Bodies."

Dr. G. W. Davis: I am quite ready to agree with many of the points made in this paper. I believe we have paid too much attention to antiseptics and too little to asepsis. We are more careful about carbolic and bichloride solutions, and too careless about cleanliness. Some years ago while discussing a paper on obstetrics in Sacramento, I said we should have less antiseptics and more cleanliness; in fact, for ten or fifteen years past I have advocated perfect cleanliness, with less *ante* and *post-partum* douches. That these powerful antiseptics are the cause of deaths and of tedious recoveries, I have no doubt. Some months ago while attending a case of miscarriage, a simple one in which everything had come away *en masse*, I desired to have a douche given and suggested boiled water. The patient's mother having used carbolic acid douches herself, asked if she could not use it with the patient. I assented, but directed that only one teaspoonful to a quart of water be employed, and that she should be sure it was well dissolved. One such douche was given in the morning, and, as I had ordered a rectal injection to precede the vaginal douche, the mother thought it well to also use carbolic acid in the enema. It was given, and the mother retired to an adjoining room, but after a short interval returned and found the patient almost in a state of collapse. Fortunately the enema soon passed, but it was three or four hours before the patient recovered. I quote this as an example of the dangerous result of using strong antiseptics. I, at first, blamed the mother, but, after hearing Dr. Liliencrantz' paper, I do not. We should be blamed for allowing any one to use such powerful agents.

Dr. C. E. Farnum: I very much favor the use of antiseptics to sterilize the skin and the hands, elsewhere they should be used with caution, but in the abdominal cavity—never. Hot water, soap, and the nail brush are my adjuncts in cleansing the hands, but we must have some germicide to apply subsequently.

Dr. H. M. Sherman: An example will best show how I stand on this question. This morning I opened a very offensive abscess of the jaw, and later had to operate at the Child's Hospital. I scrubbed my hands well with green soap, then dipped them in a permanganate solution, then in oxalic acid, then in a corrosive sublimate solution, and finally rubbed them over carefully with alcohol on cotton. This takes up the grease more rapidly than when poured on. I then repeated this whole process before operating.

Dr. J. H. Barbat: It strikes me that the question of antisepsis and asepsis develops more or less into one of common sense. It has been proven that in the ordinary puerperal canal the germs are not dangerous, and that the secretions produced during labor are sufficient to destroy all germs except, perhaps, gonococci. In miscarriages we use large quantities of hot water simply to further subinvolution.

Dr. C. G. Levison: There is one point I wish to emphasize, and that is the use of alcohol in preparing the hands. Late researches by a German investigator, who has made thorough tests, shows alcohol to be the most powerful of antiseptics. He uses soap and water and the nail brush, then alcohol, and then corrosive sublimate.

Dr. Liliencrantz: Lately we have seen a great deal about the trouble of sterilizing catgut. If it is so difficult to sterilize dead material with the use of such powerful agents, how much more difficult is it in living tissues—as in our hands for instance. I had not heard of the investigations mentioned by Dr. Levison, but should think that alcohol is the least harmful of the antiseptics, and I shall profit by his suggestion.

The Epiphyses; their Development, Functions, and Pathology.—**Dr. E. E. Kelly** read a paper upon this subject. He said: The study of the bones has always been attended with difficulties, and generally confined to *post-mortem* examinations. The soft parts have so masked the deep-seated bony framework of the body, as to throw doubt into both pathological and anatomical conditions of the osseous system. Pathological demonstrations have had to await the death of the victim, or the removal of the bone, before definite and indisputable evidence could be adduced. Courts of law and juries, with no technical knowledge of anatomy, have been appealed to to pass upon questions that could not be positively proved or disproved, until after the time when damage awards and the satisfaction of having defrauded the surgeon of his fee, could bring solace or satisfaction to the victim. The recent discoveries accompanying the use of the cathode ray are destined to revolutionize the hitherto doubtful methods of diagnosis, and make positive diagnoses where they have formerly been impossible. This new aid will prove invaluable in clearing up the pathological conditions in and around the joints. It will be especially useful in the pathology of childhood and up to the time when the epiphyses become entirely ossified and united to their diaphyses. Diseases of the joints are very common complaints in childhood and youth, and diagnosis is especially difficult on account of the difference in structure at this period of life. In the fetal skeleton long bones are cartilaginous, and ossification begins in a center within a cartilaginous mass and spreads outward toward surfaces and ends. It also begins upon the inner surface of the periosteum and extends inward. he extremities of long bones do not become ossified entirely or joined to the shaft by bony union until growth has ceased; but remain separated by a cartilaginous cushion, termed the epiphyseal cartilage. A knowledge of the period of life when the various epiphyses become ossified and joined to the shaft, has been the chief aid in differential diagnosis between epiphyseal disjunction, dislocation, and fracture in the vicinity of the articulation. In disease of the epiphyses we find retarded growth of the shaft. Separation of epiphysis from diaphysis by traumatism is very apt to occur before ossification has taken place. Poupart says it frequently occurs from slight causes. It is much more frequent in epidemics of scurvy, pyemia, and suppurative processes in general. Disjunction of the lower epiphysis of the femur is perhaps one of the most difficult cases for diagnosis, and some prominent surgeons go on record as saying that amputation and *post-mortem* examinations are the only positive means of diagnosis in such cases. Fifty of these cases are on record. The treatment of dislocations of the epiphyses is the same when reducible as in ordinary cases. If irreducible, resection or amputation is often the best treatment. Through the kindness of Dr. Philip Mills Jones, I am able to show some cathode shadowgraphs, which illustrate their great value in diagnosis of such cases, as well as in the study of the development of epiphyses and the bones as well in the live subject. The X ray makes the diagnosis of any pathological condition certain, so far as applies to the extremities. The photographs shown are mostly in connection with the development of epiphyses of the hand and radius and ulna from a child 5 years of age to adult life.

Dr. P. M. Jones: I had intended to make shadowgraphs of the epiphysis of the hand and arm for each year of life, but have been too busy to do so. The speaker then exhibited a series of six pictures, in which the ages ranged from two and a half to fifteen years. In reply to an inquiry, he said he had not as yet sufficient pictures to enable him to determine whether the bones develop as was stated in the physiologies. He looked forward to great results from the Roentgen ray. He had not taken any photographs of the pelvic bones, but he had one of a tumor of the femur; this showed the articulation of the femur and ilium and demonstrated that the growth was cancerous in character and not tuberculous as had been supposed.

Dr. J. H. Barbat: There is one error or omission in Dr. Kelly's paper. It is the lower epiphysis of the fibula, which is the first to ossify and join the shaft. The X ray will soon be indispensable in the examination of fractures. In Paris, recently, in a suit for malpractice, the X ray demonstrated a bone as being improperly set, and the patient was awarded damages.

Dr. C. G. Kuhlman: As the Courts of Massachusetts, New York and Illinois have refused to admit shadowgraphs in evidence, this process may not hold so important a place in forensic medicine as some of our more sanguine friends imagine. These are "fad" times and it behooves all of us to be somewhat conservative and less disposed to "fly off" at tangents, as some of the most prominent medical men seem, at times, inclined to do. I regret that the time of this Society should be taken up with the rudiments we learned in our text-books. The value of shadowgraphs, as compared with illustrations in the text-books of such men as Virchow, Henlé, Kolliker, Toynbee and others, is absolutely worthless.

Dr. H. M. Sherman: In the diagnosis of fractures of joints the skiagraph removes all doubt; there can be no possibility of a mistake where we have a visible fracture. Perhaps this will be an injury to the medical student, as he may lose the art of training the sense of touch in diagnosis. We cannot all have costly apparatus and we must continue to educate our finger tips and try to have a skiagraph on each finger, as it were.

Dr. G. F. Shiels: I differ with Dr. Sherman as to the term diagnosis. The main point is to make ourselves thoroughly acquainted with the diseases that confront us, and the use of anything that will aid us in so doing will be of great benefit.

Dr. Kuhlman: When we consider that the tissues represented by tuberculosis, syphilis, leprosy, actinomycosis, sarcoma, etc., all belong to the pathological class—"granulation tissue," and cannot be differentiated microscopically, and are all capable of causing tumefaction of the bones, it sounds extremely ridiculous to have any one assert that shadowgraphs which simply outline tumefactions will soon become our only scientific means of diagnosis and indications for surgical interference. Surgical interference depends upon a pathognomonic differential diagnosis. Shadowgraphy will not differentiate between an aneurism of the popliteal artery and various bony growths in that region. Photography is superior to shadowgraphy in as far as outlines are concerned, yet it is of little value in the differential diagnosis of skin diseases. Von Bergmann and others have preferred to leave a bullet in the body, as it is perfectly harmless. In a bone it simply acts as a plug, and its presence is less dangerous than the probing and cutting necessary to extract it.

Dr. Kelly: As Dr. Kuhlman says the paper presents anatomical facts, but the study of them by means of shadowgraphs is new. We cannot get dead bodies except in large cities. By this new method we can find out just how soon the epiphyses unite and all about them. There is here room for anatomical study, by the profession, of inestimable value.

SPECIAL CORRESPONDENCE.

LONDON.

[FROM OUR OWN CORRESPONDENT.]

"Ethics" and Manners at the Carlisle Meeting of the British Medical Association.—The Future of the Association.—Its Meeting in Montreal in 1897.—The Sections at Carlisle.—The General Medical Council Election.—The Army Medical Staff.—The Report of the Royal Commission on Vaccination.

I did not write to you from Carlisle, where the annual meeting of the British Medical Association was held this year, because, if the truth must be told, the meeting was not very interesting, and much of what happened was a source of grief and discouragement to old and tried friends of the Association. It has been built up by the labor of two generations of far-sighted men deeply impressed with the needs of the general body of the profession in this country, and seeing very clearly that if we are to rise it must be by mutual effort and trust. A wave of unrest and unreasoning fault-finding is passing over the profession, and to some it seems that before it has spent its force it will wreck the British Medical Association, which seems to be in danger of falling into the hands of faddists and extremists of all kinds. As, I think, I have observed before, the medical men in country districts have suffered severely by the agricultural depression which has banished the squires, and deprived the farmers of their power of spending. In towns, companies which go by the name, as a rule, of Medical Aid Societies, have set up dispensaries, with salaried medical officers and paid canvassers of the insurance agent type, who have sought, by means which are contrary to medical traditions, to attract patients to the medical aid companies. Workmen's sick benefit clubs have banded together on the same principle to employ salaried medical officers, at very low salaries too, to give medical attendance in return for subscriptions of less than a dollar a year for an adult male, and for about two dollars for a man, his wife, and family. Many men who have got to a time of life when they might reasonably expect to find their practices increasing and yielding a fairly certain income, find on the contrary, that they have decreased rapidly. Such men, smarting under a sense of failure, are ready to turn and rend their best friends. They turned the Ethical Section, at Carlisle, into a bear garden, and brought down much ridicule from the general press. They denounced the General Medical Council, they denounced the Council of the Association, they denounced the hospitals. But their denunciations were so wholesale and indiscriminating that they failed of their effect. The man in the street shrugs his shoulders and mutters "trade-unionism," while the more quiet friends of the Association tremble for its future as a scientific institution if the Ethical Section is allowed to appear at subsequent meetings.

Happily there will be little temptation to permit its formation at the next meeting, since it is to be held at Montreal, where these domestic grievances and recriminations will be a little out of place. The Montreal meeting, which will probably be fixed for the second week in September, 1897, will be a success if good organization and hearty efforts can make it so. Professor Adani, who was one of the delegates who presented the invitation, is well known in this country, having held an appointment in the University of Cambridge before receiving a call to fill the chair of Pathology in McGill University. He understands feelings and possibilities on this side and will know how to make the meeting a scientific success in all that concerns the experimental departments of medicine. In Professor Roddick, the Association will have a President who holds, deservedly, a very high position, both as a surgeon and as a citizen in the Dominion. It is not, perhaps, to be expected that a very large number of members will attend from this side, but they will almost certainly be among the best we have to send, as the season of the year is very convenient.

Of the scientific work done at the Carlisle meeting I do not find very much to say, and it is the less necessary, as it is understood that arrangements have been made for the publication of a series of supplements of the *British Medical Journal*, which will permit the whole of the proceedings of the sections of the annual meeting to be published complete before the end of September. The debate which attracted most interest was that on the new methods (Schott, of Nauheim), of treating heart disease. It was introduced by Sir Grainger Stewart (who will be the President of the association when it goes to Edinburgh in 1898), in a very elaborate review. A good deal of scepticism was expressed by several speakers as to the interpretation which has been put on the physical signs by the more ardent exponents of the method of treatment by exercises and baths devised by the brothers Schott, and some very nice points in percussion and anatomy arise. There seemed to be an admission on all hands that in suitable cases very considerable amelioration of symptoms might be hoped for and was frequently obtained. The surgical section was well attended, and there was a spirited discussion on appendicitis, and a somewhat novel essay by Mr. William Anderson on the surgery of the sub-peritoneal space, founded on an elaborate anatomical enquiry. In the Section of Diseases of Children, Dr. Ruston Parker, of Kendal, gave a very interesting lantern demonstration of some 50 cases of cretinism treated by thyroid extract. Some of his cases were drawn from the mountainous districts of Westmoreland, but others had been sent to him from Belgium and the United States.

The profession in England and Wales is about to elect three representatives to the General Medical Council, the term of office of those who have served since direct representatives were elected first under the Act of 1887, and reëlected in 1891, having come to an end. Dr. Glover is standing again, and will be reëlected, but the two other representatives, Mr. Wheelhouse and Sir Walter Foster, do not intend to stand again. There are about eight candidates for the two seats, and it is not unjust to say that there is no possibility of selecting from them men worthy to be successors to those who are retiring. There has been a good deal too much of vulgar electioneering tactics to please the quiet majority of the profession, and it is probable that even yet if a strong candidate were found he would win the day.

The dissatisfaction felt at the stupid exclusiveness of the clique which rules the army has been shown by the fact that for 25 advertised vacancies for the Army Medical Staff, there were only 26 applicants, and only 13 of these obtained the half of the maximum number of marks. As this is the minimum which qualifies for a commission, only 13 vacancies were filled up. As a matter of fact it is well known that the actual number of vacancies in the Army Medical Staff was over 40, but the War Office was ashamed to advertise the fact.

The report of the Royal Commission on Vaccination, though not formally published, is being freely discussed. It gives satisfaction to no one. It advises that if a parent has conscientious objections to vaccination, he should be permitted to make a declaration or affidavit to that effect in legal form, and should thereafter be relieved from the pains and penalties enacted by the vaccination laws. The anti-vaccinists claim this as a victory, whereas the Commission's report state that the Commissioners (all but two) are so thoroughly convinced that vaccination is the only preventive of small-pox that they have devised this method of preventing the creation of martyrs, in order to render vaccination more general and popular.

LONDON, September 2, 1896.

LONDON.

The British Medical Association and the Abuse of Medical Charities.—The extent of the evil in the United States and in Europe.—Suicide of a Physician in Paris as a result of this competition.—Necessity of the Regulation of the Charities.—Action of the Los Angeles County Medical Society noted abroad.—The Brussells Medical Syndicate.—The Syndicate requested to organize a Medical Service by several of the Societies.

It is exceedingly suggestive of the trend of professional needs and conditions all over the world, as well as of very great interest to every medical man, that the British Medical Association is addressing itself earnestly to a consideration of such important matters as the abuses of hospital and dispensary services by the public, and the suicidal scramble for lodge or club practice at nominal rates, on the part of certain medical practitioners.

In America, even more than here, there are many such issues that are becoming burning questions in these days of excessive competition on all sides. There seems, and with great good reason, to be a feeling abroad that many things demand rectification in our profession, which, by the way, has increased out of all proportion to population in most localities. We need but turn our attention for a moment toward our general environment, to observe that the majority of the institutions founded so generously and conducted so zealously for the benefit of the sick poor, whether on charitable or coöperative principles, are entering into keen competition with us, and that, of course, *greatly by our help*. The Association instances Birmingham, England, showing that the hospitals and dispensaries treated last year a grand(?) total of about 128,000 patients, out of a population of 500,000. Just think what it means. Imagine what inroads must have been made in the incomes of the rank and file of the profession. And remember that such detriment is at the hands of their brethren. Nor is this an isolated instance, but rather the rule, with amazingly few exceptions, in the towns and cities of Europe and America. It is a spectacle for the gods to laugh at; a body of learned men exerting their best efforts toward their own undoing. The worst of it all is that this philanthropy gone mad, this misguided generosity, has gone a long way toward pauperizing the public at the expense of the profession. It simply destroys the prospects of many medical men, who otherwise could get along nicely, and with benefit to the community. Assuredly it is a great injury to allow numbers of wage-earners to profess the need of charity, and to demean themselves as paupers to avoid paying fairly and in accord with their means.

As a sample of the gravity of this matter, we have but recently seen an account of the suicide of an eminent Parisian physician, a member of the Academy, who, after long years of toil, saw nothing ahead for his old age but abject poverty. In a letter written just before his death, he gave as his reasons for taking his life, that public institutions had reduced his income slowly but surely, till he could no longer make a livelihood. The statistics of last year's charitable services in Paris lend sharp emphasis to his statement.

While no one would suggest doing away with these public services, it is of vital import that they be rigorously scrutinized with a view to relegating them to the office they originally were designed to fill. In other words, the vast majority of the patients who now accept absolute charity, can undoubtedly pay something; if not a full fee, then a fraction, even though small, of a fair fee. At all events, some such active measures should be resorted to. And that the profession will be compelled to move vigorously, at some time, no one doubts. It will, therefore, be interesting to observe how much injury and punishment it will first stand.

In this connection, I am delighted to hear it remarked, here in London, that the Association in Los Angeles, California, has taken a stand in the premises that is in the right direction of ostracising the physician who does contract work.

The largest and strongest fight is still in progress in Brussels. In that city a great majority of the medical men have joined a union, and subscribed for one or more shares in a Medical Syndicate, having as its object the conservation of medical interests, and the undoing of all systems tending to lower the dignity and destroy the just remuneration of the profession. It is admirable to observe how thoroughly the men have lived up to and fought the matter step by step. Nearly all the professional men in the city have joined the Syndicate; and to some, at least, it has meant a temporary sacrifice, as they gave up their contract work to join. For these, however, the Association very properly made an allowance from their funds to remedy this grievance while the matter was *sub judicc.* The fight is still on, but the certainty of victory lies with the Medical Syndicate, for the simple reason that the outsiders in the profession are gradually coming into the ranks, and, as a natural sequence, the clubs, lodges, and mutual federations of all kinds cannot, with a very few exceptions, get men of good standing to care for them; and the public is aware of this fact and exhibits a decided hesitation to be treated by objectionable men—"the rag-tag and bob-tail" of the profession, as it were.

Already three societies have come to the Medical Syndicate asking this association to themselves organize their medical aid service. One of these societies alone has a membership of 500, and the probability of supervision by the Syndicate has already increased their numbers. It is more than likely that in due time the medical aid of all societies and clubs will be under the direct control of the syndicate, which will assuredly see that every patient pays who reasonably can pay, and that he pays a just and reasonable fee for his medical attention, due regard being had for the really poor. Thus, if the care of various associations can be made to pay in reason, the net proceeds can be divided with perfect propriety among the members of the Medical Syndicate. Thus, too, a proper scale of fees can be made from the laborer to the millionaire; and there will be less friction in consequence of the removal of these long-standing causes of irritation among practitioners of medicine. Eventually it would be in order to examine the lists annually with care, and strip off those who could afford to pay a full fee, This idea has, I understand, been put into practise with the three societies who put themselves under the care of the Syndicate. The Brussels Medical Syndicate has practically accomplished, after a year's sustained fight, a grand triumph. They are to-day more numerous, richer, better disciplined, and more in accord than a year ago. The profession throughout the world is deeply indebted to them for the incalculable benefit involved in the object-lesson.

E. J. BOYES, M.D.

LONDON, July 20, 1896.

CORRESPONDENCE.

The Wisconsin Eclectic Medical College--Diplomas by Mail.

Sir: If anybody is of the opinion that there is no way of obtaining a diploma in medicine save by faithful study and the expenditure of time and money, let him at once disabuse his mind of the notion, for along with the other achievements of the age, there has been discovered a ready method of making doctors. Explicitly and in brief, your raw material can be taken in, moulded into shape and turned out a finished product, with a guaranteed Latin label attached, all in the short period of two weeks. Lest any should be inclined to doubt this somewhat startling statement I beg leave to submit the following facts. A youthful acquaintance of mine, of an inquiring turn of mind and not lacking in ambition, replied to an advertisement he had seen in the San Francisco *Chronicle*, wherein it was stated that persons looking for an unusual opportunity to acquire medical diplomas would find it to their advantage to address the advertisers. Following is the young man's application, which is introduced, not that it is essential to an understanding of the matter, but because as a literary effort it seems worthy of being rescued from oblivion :

"MEDICUS," CHICAGO, ILL., *Dear Doctor:* Seeing your ad I wish to say will be pleased to learn particulars as to diploma. Will say am 20 years of age and have some knowledge of drugs and medicines, as I worked awhile in a drug store. Am anxious to get a diploma as soon as possible as I know a place where I could make some money. State charges, how much in advance and how much when I get diploma. Would not mind paying a little more if I could get diploma quick. Could I study at home and how long would I have to study? Do not fail to state how soon I could get diploma, also the cheapest. Awaiting early reply I remain, yours truly, ——— ———

P. S. Kindly let me know exactly the time I can get diploma (the quicker the better) as I know a place where I can make some money.

This urgent appeal brought forth a prompt response in the shape of a letter and a package of printed matter from the Wisconsin Eclectic Medical College of Milwaukee. Among the papers was a "*fac simile* copy of our charter," "a reduced cut of our diploma," together with a voluminous "prospectus" and an "examination blank." After taking vigorous exception to "the unjust and unreasonable laws in force in all other medical colleges, compelling students to attend said colleges a certain number of terms of years before they are granted a diploma conferring the degree of M. D.," it is explained that by the simple process of filling out the examination blank and remitting thirty-five dollars to Fred. Rutland, Ph. D., M. D., of 1001 West Congress street, Chicago, one may obtain a parchment issued by a legally chartered college and signed by half a dozen or more professors; declaring one to be a doctor of medicine with all the rights and privileges pertaining to the title. I am not aware whether it is generally known that such an establishment exists, but in view of the remarkable results accomplished I feel that information regarding the institution can not be too widely disseminated. I am etc.,

Rocklin, Cal. BRADFORD WOODBRIDGE, M. D.

REVIEWS AND NOTICES.

DIET FOR THE SICK. Contributed by Miss E. Hubbard, Principal of Nurses' Training School, Grace Hospital, Detroit; and Mrs. Emma Drant, Matron of Michigan College of Medicine Hospital, Detroit. Second edition. Enlarged. The Illustrated Medical Journal Company. pp. 100. Price, limp cloth, 25 cents.

In this little book there is, besides the useful formulæ for "sick dishes," foods and cooling drinks for convalescents, quite complete diet tables for use in anemia, Bright's disease, calculus, cancer, chlorosis, cholera infantum, constipation, consumption, diabetes, diarrhea, dyspepsia, fevers, gout, nervous affec-

tions, obesity, phthisis, rheumatism, uterine fibroids. It also gives various nutritive enemas. The physician can use it to advantage in explaining his orders for suitable dishes for his patient, leaving the book with the nurse.

THE AMERICAN YEAR-BOOK OF MEDICINE AND SURGERY, being a yearly Digest of Scientific Process and Authoritative Opinion in all branches of Medicine and Surgery, drawn from Journals, Monographs, and Text-books of the leading American and Foreign Authors and Investigators. Collected and arranged with critical editorial comments, by J. M. Baldy, M.D., C. H. Burnett, M.D., Archibald Church, M.D., C. F. Clarke, M.D., J. Chambers DeCosta, M.D., W. A. N. Dorland, M.D., V. P. Gidney, M.D.. Homer W. Gibney, M.D., Henry A. Griffin, M.D., John Guitéras, M.D., C. A. Hamann, M.D., H. F. Hansell, M.D.. W. A. Hardaway, M.D., T. M. Hardie, B.A., M.D., C. F. Hersman, M.D., B. C. Hirst, M.D., E. Fletcher Ingals, M.D., W. W. Keen, M D., H. Leffmann, M.D., V H Norrie, M.D., H. J. Patrick, M.D., Wm. Pepper, M.D., D. Riesman, M.D., Louis Starr, M.D., Alfred Stengel, M.D., G. N. Stewart, M.D., Thompson S. Wescott, M.D. Under the general editorial charge of George M. Gould, M.D. Profusely illustrated with numerous wood-cuts in the text, and 33 handsome half-tone and colored plates. Philadelphia: W. B. Saunders. pp. 1184. Price: cloth, $6.50; half morocco, $7 50.

It is difficult for the reviewer in these days, when the fecundity of medical literature is unparalleled, to at all times decide whether the appearance of a new book is justified by the demands for its existence. In the case of the "American Year-Book of Medicine and Surgery," we have no hesitation in saying that it will create a place for itself, and a demand which will increase for a long time to come. According to the editor, Dr. George M. Gould, the general design of this work has been "to give to physicians in a compact form an annual epitome of the new and progressive medical truths or suggestions published during the months of the preceding year from July to June inclusive." "Sharp distinction has been made between a summary of medical progress and the literary review of all published matter." In this work the aim has been "to mention only those things that are or may be contributory to the progress of medical science and art." "Judicial criticism is also desirable, not only to select and summarize, but also to pronounce decisions upon proposals and to prevent useless experiments by others. A mere colorless, heterogeneous mass of abstracts from medical literature leaves the average reader bewildered or in the position of an amateur experimenter." The present volume contains 1184 pages. In this the contents have been collated under the usual general heads. Amongst the editorial staff we notice the names of Pepper, Keene, Baldy, Starr, and Ingals, with others well known though perhaps less familiar. A detailed analysis of a work of this kind is here out of place; in fact, the quotations already made from the editor's preface, fully explain the scope of the work and are amply justified by the text. The typography is clear, the paper good, and the illustrations are excellent and at the same time exceedingly numerous. Besides the engravings in the text there are 33 full sized plates, many of which are in colors. The value of plates, when explanatory of new operations, new methods, and of pathological conditions, is inestimable in a work of this kind, and adds enormously to its utility. By far the most valuable feature of the volume is the element of judicial criticism to which we have already referred. Incorporated in the text, but inclosed in brackets, are the comments of the editor, while sometimes they embody their individual judgment. Upon no mooted point have these been omitted, and in every case where the perusal of the text might lead to a difference of opinion, a conscientious effort has been made to guide the reader in the right direction. In these expressions of opinion, there has been no attempt to defend and uphold the modern "faddist," every comment, apparently, being made with great impartiality. We have no hesitation in recommending this book to the favorable consideration of the profession, and more especially to that of the general practitioner, as a valuable aid in every day work. Its moderate price for the amount and character of the matter which it contains, will serve to perpetuate it as a yearly visitor to large numbers of the profession.

ANTITOXIN-BEHRING. Victor, Koechl & Co., the agents in the United States for the Behring serum have recently issued a pamphlet, which includes reprints of quite a number of papers that have been published in this country on the use of antitoxin in diphtheria, together with extracts from medical journals bearing on the subject. Tables of statistics are included, and there are also brief remarks on the indications, dosage, and method of using this remedy.

COCA AND ITS THERAPEUTIC APPLICATION. By Angelo Mariani. Illustrated. Third edition. New York: J. N. Jaros. pp. 68.

This is the title of a handsome little brochure, profusely illustrated and issued by M. Mariani, whose name has long been identified with coca wine. It contains a great deal of information relating to the botany of the plant, as well as the gathering of the crude drug, and the application of the finished product in therapeutics.

THE NEWER REMEDIES—A REFERENCE MANUAL FOR PHYSICIANS, PHARMACISTS, AND STUDENTS. By Virgil Coblentz, M.A., Phil. D., Professor of Pharmacy and Pharmaceutical Chemistry in the New York College of Pharmacy. Second edition, revised and enlarged. New York: D. O. Haynes & Co. pp 82. Price, 50 cents.

This little booklet consists of a very complete list of the newer remedies, particularly those of the coal tar series, with their innumerable compounds. The practitioner will find it a very valuable source of reference, as the multitude of these laboratory products is already bewildering. McKesson & Robbins, of New York, inform us that they will furnish a copy free to any physician who requests it.

SYPHILIS IN THE MIDDLE AGES AND IN MODERN TIMES. By Dr. F. Buret, Paris, France. Translated from the French, with notes, by A. H. Ohmann-Dumesnil, M. D., Professor of Dermatology and Syphilology in the Marion Sims College of Medicine; Consulting Dermatologist to the St. Louis City Hospital, etc. Volumes II and III of "Syphilis To-Day and Among the Ancients," complete in three volumes. Philadelphia: The F. A. Davis Co.; pp. 300. Extra cloth, $1.50 net.

The book, containing about 300 pages, includes two volumes of the work entitled "Syphilis To-Day and Among the Ancients," the first volume having been already published. The work is historical and traces the existence of the disease even among the Assyrians and Babylonians, and among the most ancient people of America. The author has paid special attention to the refutation of the opinion that the disease originated in America. The style of writing is decidedly French, and the text is illustrated with stories pertaining to the subject.

MEDICAL NEWS.

LICENTIATES OF THE BOARD OF EXAMINERS.

At a meeting of the Board of Examiners, held August 4, 1896, the following were granted certificates to practise medicine in this State:

Fulvio Bonino, San Francisco; Univ. Geneva., Switz., Oct. 4,'90; Univ. Bologna, Italy, Nov. 14,'90.
Fredk. J. Carter, San Francisco; Lic. Soc. Apoth., Aug. 10,'93; Royal Coll. Phys., Lond., Oct. 25,'94; Royal Coll. Surg., England, Nov. 8,'93.
Carlton W. Faull, San Francisco; Med. Dept. Univ. Oregon, April 1,'96.
John V. Gaff, Los Angeles; Ensworth Med. Coll., Mo., Feb. 28,'89.
Harry S. Greenleaf, Alameda; Med. Dept. Univ. Pennsylvania, June 13,'95.
Frank M. Keenan, San Francisco; Detroit Med Coll., Mich., April 30,'96.
Robt. Lowry, Jr., San Francisco; Louisville Med. Coll., Ky., Feb. 25,'87.
Max Strunsky, San Francisco, Bellevue Hosp Med. Coll., N. Y., Mar. 23,'96.
Rodney A. Toms, Springfield; Baltimore Med. Coll., Md., April 15,'90.
Herbert [illegible]. Walls, Los Angeles; Coll. Med., Univ. Southern Cal., June 3,'96.
Clarence L. Heller, San Francisco; Med. Dept. Univ. of Cal., July 13,'95.
Wilfred H. Kellogg; Palo Alto, Med. Dept Univ. of Cal., May 13,'96.
A. L. J Latigau, San Francisco; Med. Dept. Univ. of Cal., May 13,'96.
James D. Murphy, San Francisco; Med. Coll., Univ. of Cal., May 13,'96.
J. H. O'Brien, San Francisco; Med. Dept. Univ. of Cal., May 13 '96.
George L. Painter, Oakland; Med. Dept. Univ. of Cal., May 13,'96.

CHAS. C. WADSWORTH, Secretary.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department of the U. S. Army (Division of the Pacific) from August 20, 1896, to September 20, 1896.

First Lieutenant John S. Kulp, Assistant Surgeon, is relieved from temporary duty at Fort Sherman, Idaho, and will rejoin his proper station, Fort Walla Walla, Wash. Par. 2, S. O. 141, Dept. of the Columbia, Aug. 25,'96.

Major James P. Kimball, Surgeon, is relieved from duty at Fort Wingate, New Mexico, and ordered to Fort Columbus, N. Y., for duty, relieving Major John Van R. Hoff, Surgeon.

Major Hoff, on being thus relieved, is ordered to Vancouver Barracks, Washington, for duty, relieving Captain Rudolph G. Ebert, Assistant Surgeon

Captain Ebert, on being thus relieved, is ordered to Philadelphia, Penn., for duty as attending surgeon and examiner of recruits, relieving Captain William W. Gray, Assistant Surgeon.

Captain Gray, on being thus relieved, is ordered to Fort Apache, Ariz., for duty, relieving First Lieutenant Irving W. Rand, Assistant Surgeon.

Lieutenant Rand, being thus relieved, is ordered to Fort Clark, Texas, for duty.

First Lieutenant William E. Purviance, Assistant Surgeon, is relieved from duty at Fort Sherman, Idaho, and ordered to Fort Columbus, N. Y., for duty, relieving First Lieutenant Thomas J. Kirkpatrick, Jr., Assistant Surgeon.

Lieutenant Kirkpatrick, on being thus relieved, is ordered to Fort Douglas, Utah, for duty, relieving First Lieutenant George D. De Shon, Assistant Surgeon.

Captain Louis Brechemin, Assistant Surgeon, is relieved from duty as attending surgeon and examiner of recruits at Baltimore, Md , to take effect on completion of his examination for promotion, and is ordered to Fort Sherman, Idaho, for duty.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service (District of the Pacific) from August 20 to September 20, 1896.

J. B. Hamilton, Surgeon, when relieved from duty at Chicago, Illinois, to proceed to San Francisco, Cal., and assume command of service.

John Godfrey, Surgeon, when relieved from duty at San Francisco, Cal., to proceed to Chicago, Ill., and assume command of service.

S. D. Brooks, Past Assistant Surgeon, directed to rejoin station at St. Louis, Mo., and when relieved from duty at that place, to proceed to Port Townsend, Wash., and assume command of service.

W. G. Simpson, Past Assistant Surgeon, relieved from command of service at Port Townsend, Wash., on arrival of S. D. Brooks, Past Assistant Surgeon.

ITEMS.

Dr. A. Eichler has removed from Webster Groves, Mo., to 517 Jones street, San Francisco.